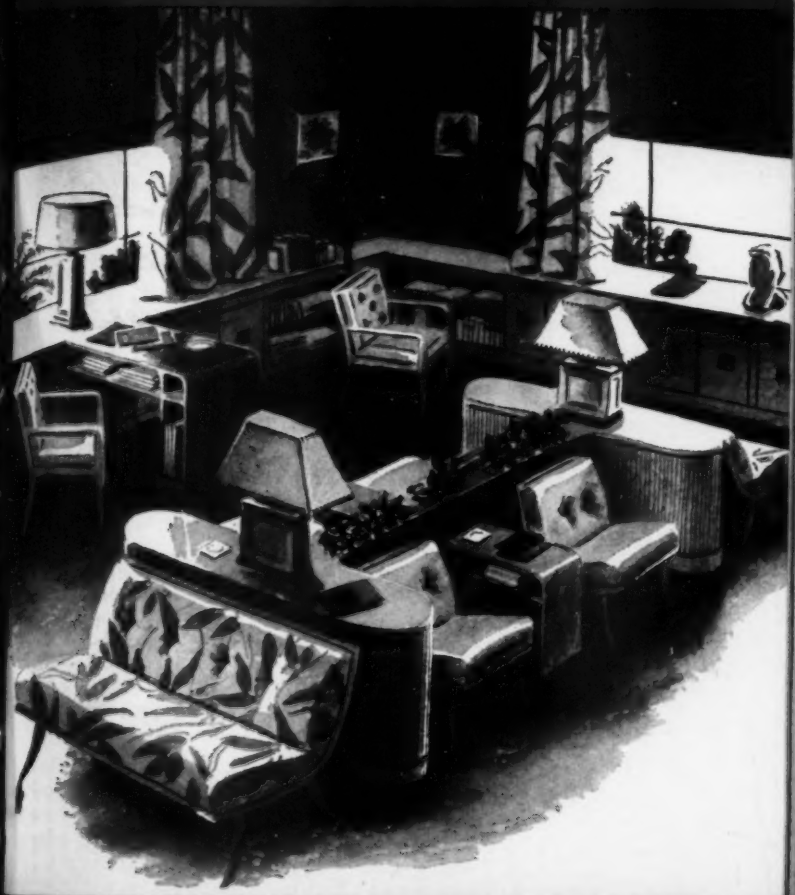
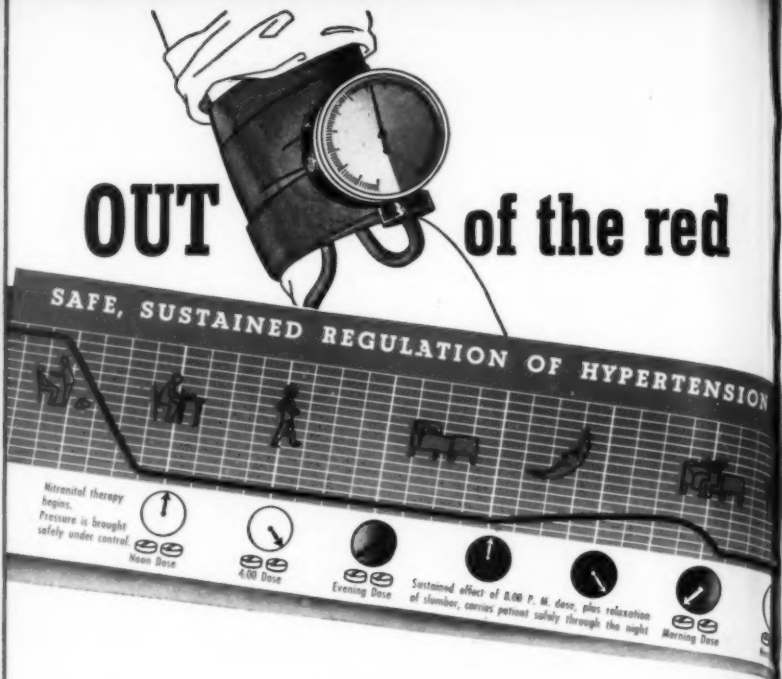
July Medical Economics

25TH YEAR OF PUBLICATION



★ For Those Who Want Some Price . . . See Page 24



Vasorelaxation produced by Nitranitol is GRADUAL, avoiding the dangerously abrupt blood pressure fluctuations of the quick-acting drugs.

The hypotensive effect of Nitranitol is PROLONGED, each dose overlapping the one before—permitting maintenance of a relatively constant pressure.

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Gradual, Prolonged, Safe Vasodilation with

NITRANITOL

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Nitranitol contains ½ gr. mannitol hexanitrate in each scored tablet. Dosage is 1 to 2 tablets every four hours. Available in hospital and prescription pharmacies in bottles of 100 and 1000.

For cases requiring sedation in addition to vasodilation.

NITRANITOL

WITH

PHENOBARBITAL

Each scored tablet contains ½ gr. mannitol hexanitrate and ¼ gr. phenobarbital

Bottles of 100 and 1000.

MERRELL 1828

THE WM. S. MERRELL COMPANY
CINCINNATI, U. S. A.

Medical Economics

* * * *July 1948* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Cont.*]

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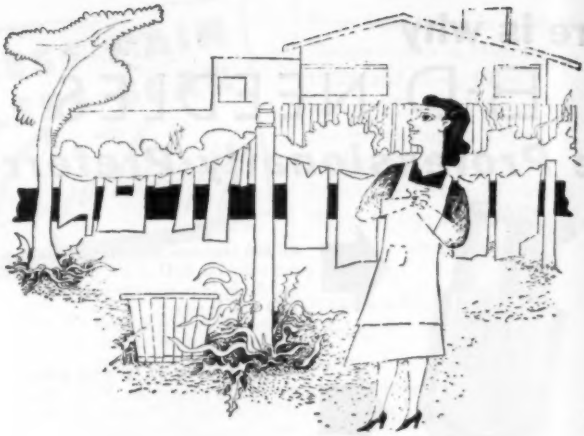


There'll be fewer hankies *on Backyard Lines this season*

And more hay fever victims than ever before will be telling the world about their freedom from the miseries of hay fever. Antihistaminics are the reason, and a potent addition is Abbott's new and different compound, THENYLENE Hydrochloride.

With THENYLENE, severe side-reactions are rare. In a recent study, the investigators reported that with a dosage of 100 mg. of THENYLENE, the incidence of undesired reactions was only about 25 percent, and in practically all instances a reduction in dosage to 50 mg. obviated the side-effects.[1]

Try THENYLENE in cases where your experience with other antihistaminics has been disappointing. Leading allergists point out that one agent may bring definite relief where another has failed. For severe symptoms 100 mg. of THENYLENE three or four times daily is suggested. As a maintenance dose or for mild symptoms, 25 to 50 mg. may be prescribed. Wherever possible antihistamine drugs should be used with specific desensitization.

Prescription pharmacies everywhere have THENYLENE Hydrochloride in 25-mg., 50-mg. and 0.1-Gm. sugar coated tablets in bottles of 100 and 500. For a FREE SAMPLE and descriptive literature, drop a card to ABBOTT LABORATORIES, North Chicago, Illinois.

PRESCRIBE

Abbott's NEW antihistaminic

Thenylene

HYDROCHLORIDE

(Methapyrilene Hydrochloride, Abbott)

1. Friedlaender, A. S. and Friedlaender, S., Amer. J. Med. Sc., in press.

How its special vehicle makes

Acnomel

a significant advance, clinical and cosmetic, in acne therapy

ACNOMEL's superior vehicle embodies an entirely new principle in topical acne therapy. To this vehicle —a stable, grease-free, flesh-tinted hydrosol— Acnomel owes the following important advantages:

1. It is easy to apply smoothly and evenly.
2. Upon application, it dries in a few seconds.
3. Its active ingredients are maintained in intimate and prolonged contact with the affected areas.
4. It removes excess oil from the skin.
5. It is readily washed off with water.

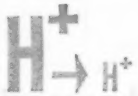
Available, on prescription only, in specially-lined 1½ oz. tubes.

Smith, Kline & French Laboratories *Philadelphia*

Active ingredients: resorcinol, 2%; sulfur, 8%.

TĪTRALAC

This unique antacid provides prompt and prolonged



relief from distress due to gastric hyperacidity

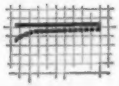
without untoward effects, even in excessive doses.

One pleasant-tasting TĪTRALAC tablet is

equivalent in acid-neutralizing power to

an eight ounce glass of fresh milk.

Each tablet contains 0.15 gm. glycine plus 0.35 gm. calcium carbonate to provide . . .



a titration curve comparable to that of fresh milk.

TĪTRALAC

Supplied in bottles of 100 tablets.

Schenley Laboratories, inc.

350 fifth avenue, new york 1

Panorama

Health officials of five states, convening in Bedford, Ind., to discuss sanitation, had luncheon in restaurant, promptly came down with food poisoning . . . Bone and cartilage for transplantation being stored in deep-freeze chest at University of Pennsylvania's new "bone bank" . . . Hearing-aid manufacturers complaining that the set adopted by British Government for free distribution under national medical program is unsatisfactory and already obsolete . . . New York's late Dr. William Stewart Philp wore rubber gloves when dining with his wife to "insulate himself against her vibrations," according to testimony in $400,000 will contest.

A "most virulent poison" reportedly isolated by Dr. Ryon Riegel of Northwestern University. According to a co-worker, four ounces in water supply of city of 75,000 would kill all the town's inhabitants . . . Gold-headed cane, in whose hollow knob seventeenth-century doctor carried "protective herbs," adopted by University of California medical school as award for student "most likely to succeed" . . . Relatives of mentally ill ex-G.I.'s getting new booklet from V.A. hospitals; it explains proper personal attitude toward patients, urges optimism because "a great many get well and a large number stay well."

National political conventions being what they are, twenty-six prominent Philadelphia physicians have formed committee to give emergency medical service to Republican and Democratic delegates. They'll hold themselves in round-the-clock readiness to contend with band-wagon apoplexy, smoke-filled-room asphyxia, Wallace jitters, and lesser hazards . . . Driver dozes at wheel, alarm rings and wakes him: New


tempering the cycle...
In the absence of organic pathology in various aberrations of the menses, Ergoapiol (Smith) with Savin often provides desirable symptomatic relief. For this reason, many physicians prefer Ergoapiol (Smith) with Savin—a preparation containing all the alkaloids of ergot (prepared by hydro-alcoholic extraction), plus oil of savin and apiol. Besides inducing pelvic hyperemia, Ergoapiol (Smith) with Savin exerts a sustained tonic action on uterine musculature, as well as a hemostatic effect.
INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.
GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.
HOW SUPPLIED: In ethical packages of 20 capsules each, on a physician's prescription only.
May we forward your copy of the new 20-page brochure, "Menstrual Disorders—Their Significance and Symptomatic Treatment"?
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ERGOAPIOL (SMITH) WITH SAVIN

safety device invented by Drs. John L. Kennedy and Roland C. Travis of Medford, Mass., has headgear to measure electrical impulses of brain, sets off alarm when they weaken.

Farmers must get "preferential," not marginal, medical care if the rest of us want to go on eating, says Dr. Edward L. Bortz, AMA president . . . Religious leaders delighted with recent 40 per cent decline in V.D. cases among G.I.'s. They ascribe it to "moral campaign" that supplanted prophylaxis instruction . . . A $3 statement, mailed twenty-six years ago by the late Dr. Harrison H. Hayward, Randolph, Vt., was recently returned to his son via the dead-letter office . . . Sister Kenny handicapped in setting up treatment centers (she has only two in this country) by lack of qualified technicians. Only twenty technicians have completed her two-year training course.

Dog's Life: American Animal Hospital Association recently heard L. C. Moss, D.V., report that associating with certain human beings drives some dogs insane . . . Response to recently established cancer detection centers has been overwhelming, says American Cancer Society; some are booked a year in advance, others will take no more applications . . . At least 1,500 displaced doctors, unable to practice in adopted lands because of legal technicalities, are being maintained by International Refugee Organization. Their predicament is under study by World Medical Association, whose new secretary-general is AMA Trustee Louis H. Bauer.

Rehearsal of top-drawer New York orchestra blew up recently when all four clarinetists left to deliver babies; Doctors Orchestral Society (seventy M.D. members) had to call it a day . . . Waiting lists of veterans' hospitals swelling month by month, V.A. reports; vast majority of applicants seeking free care for non-service-connected ailments . . . New assistant secretary of AMA, 38-year-old Dr. Ernest B. Howard, is public health man and former V.D. authority in Army Surgeon General's office.

75% to 85% of Patients Relieved
Less than 10% Reactions

Higher Milligram Potency

makes Decapryn effective at dosages well *below* the average threshold of drowsiness

The New Antihistaminic

DECAPRYN®

Pronounced "Dee-KAP-rin"

Gives your patients effective relief with fewer side effects

HIGHLY EFFECTIVE

75% to 85% of patients relieved (hay fever, allergic rhinitis, urticaria and itching dermatoses) in extensive clinical investigations.[1,2,3,4]

FEWER REACTIONS

DECAPRYN Succinate, with a milligram potency 2 to 4 times stronger than other histamine antagonists, produces an effective clinical response with correspondingly lower dosages . . . dosages that are well below the "toxic threshold" of the majority of patients. Brown[1] reports that side effects, such as drowsiness, occur in "probably less than 10% of the cases" at the effective dosage level—and are seldom severe enough to require even temporary withdrawal of medication.

LONGER DURATION

Feinberg[2] reports "longer action as compared to other antihistaminic drugs," while Sheldon[3] found that "symptoms were relieved from 4 to 24 hours after a single dose of Decapryn—which is a more lasting effect than that reported for other antihistaminic compounds."

PATIENT PREFERENCE

Of 48 patients in one clinical study[1] who had previously taken other antihistaminics, 43 (90%) elected to continue on DECAPRYN therapy.

DOSAGE

One-half to one tablet (12.5 to 25 mg.) 2 to 4 times daily, depending on the individual. Clinical studies show maximum benefits obtained with minimum effective dosage. Higher dosages of Decapryn are unnecessary and increase the possibility of drowsiness and other reactions.

1. Brown, E. A., Weiss, L. R., and Maher, J. P.: The clinical evaluation of a new histamine antagonist "Decapryn," Annals of Allergy. 6:1-6 (1948).
2. Feinberg, S. M., and Bernstein, T. B.: Histamine Antagonists. X. A new antihistaminic drug (Decapryn), J. Lab. & Clin. Med. 33:319-324(1948)
3. Sheldon, J. M., Weller, K. E., Haley, R. R., and Fulton, J. K.: Clinical observations with Decapryn, a new antihistaminic compound, Univ. Mich. Hosp. Bull. 14:13-15 (1948).
4. MacQuiddy, E. L.: Personal communication.

Decapryn (brand of Doxylamine) Succinate—25 mg. scored tablets—available at prescription pharmacies in 100's and 1000's

THE WM. S. MERRELL COMPANY

CINCINNATI, U. S. A.

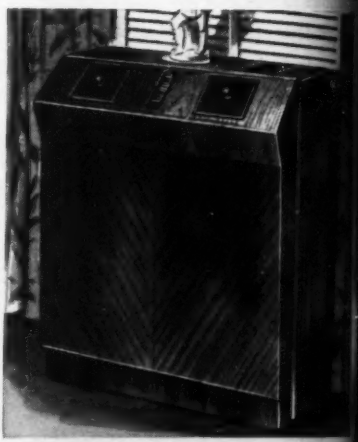
MERRELL 1828

Take the sizzle out of summer

WITH A PHILCO SINGLE-ROOM

Air Conditioner

IT'S sensational the way it drives the temperature *down* and sends your spirits *soaring* at the flick of a switch, even on the stickiest days. It pulls in fresh air from outdoors, filters out dust and pollen, cools the air, circulates it, without draughts; pumps out stale air and smoke in *any* season, independent of cooling. Quiet and inexpensive to run. Attractive in appearance. Simple controls, like a radio. Your patients appreciate a place that's Philco-cool and comfortable. At your Philco dealer's.



PHILCO MODEL 91-C. A new, single-room air conditioner in a beautiful walnut console of matched grain. Ample power to serve offices up to 500 sq. ft. maximum, with normal ceiling height. Ventilation independent of cooling lets you push out smoke and stuffy air, even in Winter. Inexpensive, easily replaceable filter. Console is 39⅛" high, 32⅜" wide, 19⅞" deep.

PHILCO

Famous for Quality the World O

One stands out

Among the profusion of new antihistaminics to choose from today *one stands out.*

Trimeton

(BRAND OF PROPHENPYRAMINE)

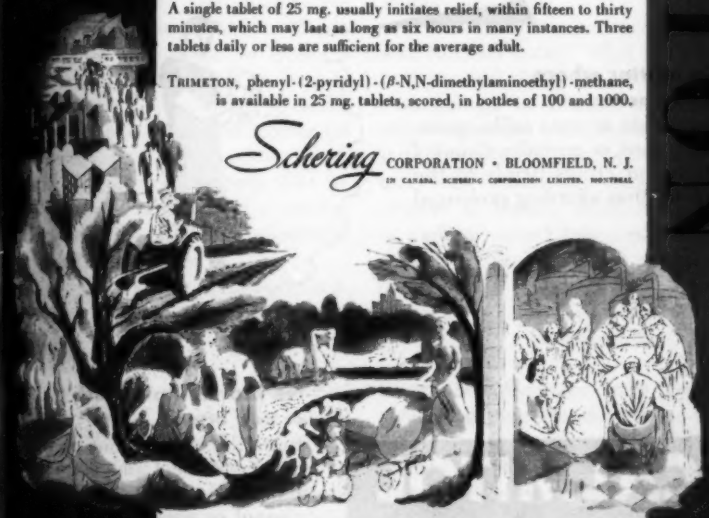
TRIMETON not only meets the demand for a preparation with fewer side effects, but it is also approximately twice as potent as other available antihistaminics. Selected by Schering's research staff after four years of experimentation TRIMETON has been thoroughly tested in the laboratory and clinic. TRIMETON provides the allergic individual with rapid and prolonged relief from hay fever, allergic rhinitis, urticaria, allergic eczema, and some cases of asthma.

A single tablet of 25 mg. usually initiates relief, within fifteen to thirty minutes, which may last as long as six hours in many instances. Three tablets daily or less are sufficient for the average adult.

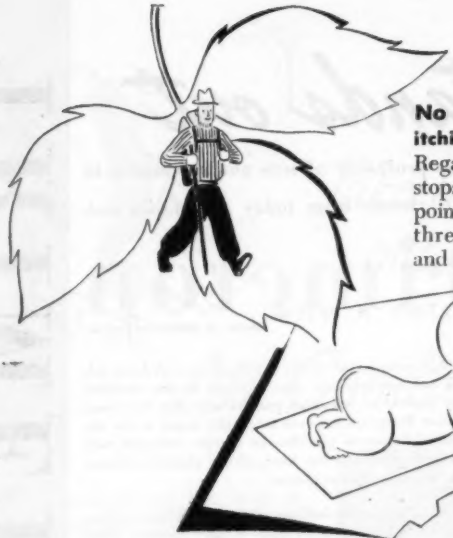
TRIMETON, phenyl-(2-pyridyl)-(β-N,N-dimethylaminoethyl)-methane, is available in 25 mg. tablets, scored, in bottles of 100 and 1000.

Schering CORPORATION • BLOOMFIELD, N. J.

IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL



TRIMETON



No matter why
itching occurs
Regardless of etiology, Calmitol stops pruritic sensation at the point of origin by raising the threshold of receptor organs and sensory nerve filaments.

No matter where
itching occurs
Regardless of site—axilla, groin, nates, anus, or genitalia, Calmitol Ointment clings firmly to the lesions, thus affording prolonged relief.

No matter how much
or how often
Regardless of extent or frequency of use, Calmitol is safe. It does not contain harmful phenol or cocaine. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate, will not be absorbed systemically.

CALMITOL

Thos. Leeming & Co. Inc.

155 EAST 44TH STREET, NEW YORK 17, N.Y.

Speaking Frankly

Dividend

After forty or more years of paying dues to his medical and specialty societies, the doctor who retires from active practice should be entitled to inactive status. He should be able to claim continued membership on a non-paying basis.

The retired physician no longer needs the legal protection of his medical society for malpractice suits. He is content to leave medicine's policy-making to younger men. But if he desires to keep in touch with professional progress, he should be permitted to receive his societies' publications without cost. The doctor who has paid dues religiously for almost half a century deserves that token of appreciation from his colleagues.

James A. Brussel, M.D.
Willard, N.Y.

Phoney

Patients annoyed by a busy signal when they call up the doctor should realize that it's caused by other patients seeking medical advice by phone. Within two hours one morning, my office phone rang sixty-three times. Requests for off-the-cuff prescriptions ran the gamut. If the patient would merely state his ailment and make an appointment to discuss it, the busy signal wouldn't be heard so often.

Campbell Harvey, M.D.
Pontiac, Mich.

Licensure

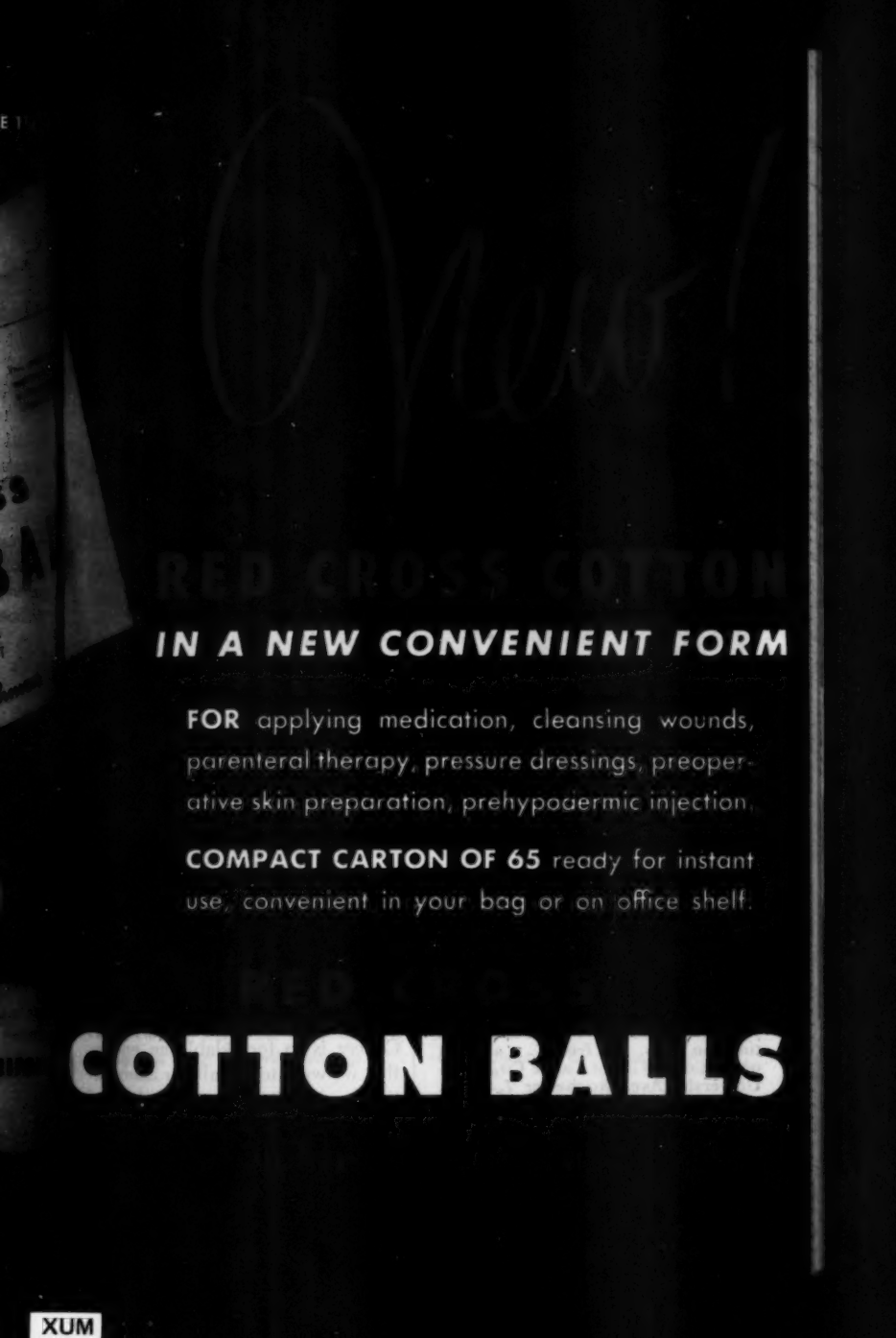
I should like to ask Florida's State Board of Medical Examiners a few simple questions:

Why has Florida no reciprocity with forty-six states? What are you trying to find out by the state board examinations in Florida that has not already been found out by other state boards? If out-of-state doctors were competent enough to practice in Florida hospitals while in uniform, aren't they competent enough to practice there now as civilians?

Harold I. Korn, M.D.
Poughkeepsie, N.Y.

Ex-service physicians have been aided in getting Florida licenses to the fullest extent possible under Florida statutes. The state board is composed of ten mature and reputable physicians whose duty is to administer the law courteously, im-


ACTUAL SIZE !
45 COTTON BALLS
RED CROSS
COTTON BA
STERILE
ABSORBENT
Johnson-John
ABSORBENT
STERILE
CONVENIENT
ECONOMICAL


IN A NEW CONVENIENT FORM
FOR applying medication, cleansing wounds, parenteral therapy, pressure dressings, preoperative skin preparation, prehypodermic injection.
COMPACT CARTON OF 65 ready for instant use, convenient in your bag or on office shelf.
COTTON BALLS

partially, and justly. That they do so is the consensus of dozens of physicians with whom I have talked. There are dissenters, of course, as exemplified by the foregoing letter. But we get only about one such letter each year.

Harold D. Van Schaick, M.D.
State Board of Medical Examiners
Miami Beach, Fla.

Detectors

In Dr. Henry A. Davidson's recent article, "Cancer Detection Centers: Boon or Bane?" the boon side wins the day. On paper, the detection center is an excellent idea. In practice, it often falls short of its mark in the quality of examinations given. And if strictly confined to persons without symptoms, the yield is only one per thousand cases.

We on the Pacific Coast believe that every doctor's office should be a detection center. Our four-fold program combines the efforts of:

1. Information centers.
2. Detection centers (every doctor's office).
3. A consultative tumor board.
4. The treating physician (surgeon, radiologist, or internist).

Cancer is being licked slowly but surely—by doctors, not by "centers."

L. Henry Garland, M.D.
San Francisco, Calif.

Cancer is so formidable an enemy that we want to use all our ammunition against it—clinics *and* doctors' offices, detection centers *and* tumor boards. If, as my critic says, detection centers discover one case of

cancer in a thousand, then this justifies their operation.

Doctor Garland is right in urging that every doctor's office be a detection center. Unfortunately, few practitioners can arrange their time to devote 45-60 minutes to a "well" patient. If we had more physicians who, like Doctor Garland, would be willing to do this, it would be a blessing.

Henry A. Davidson, M.D.
Flemington, N.J.

Immigrants

Some time ago the program of the New York State Department of Health was reported in danger of failure because physicians refused to give up private practices to accept public health positions. This looked like a good chance to squelch complaints from the foreign-trained physicians who balk at the high cost of starting a private practice. Why didn't they accept some of these openings?

A physician trained at a German university gave me the answer. Despite his New York license, he was turned down for a position because his medical school was not approved by the AMA and because only graduates of approved medical schools are accepted for these positions.

On the surface, this seems like a fair, protective measure. But when we consider that foreign schools get neither the approval nor the disapproval of the AMA, the regulation becomes restrictive instead of protective. It is restrictive not only to

the foreign-trained physician but to a public that would profit from the work such physicians could do.

M.D., New York

Bristles

That letter from a California M.D. makes me bristle with shame for a still honored profession. What kind of person is this who says, "I see 120 people a day" and "a new patient requires only fifteen minutes"?

"Treating the most," even among the suckers that "continue to come back," isn't medicine. Such brazen pill-peddling floors me. Does he use bumblebee feathers and sparkling lights to make his diagnosis?

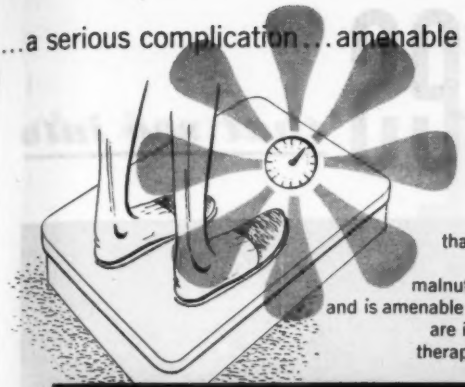
James L. Wade, M.D.
Parkersburg, W. Va.

Bankers

Your recent article about blood banks made many good points. But it failed to mention the adverse influence upon independent investigation that would result from the research controls advocated by Admiral McIntire of the American Red Cross. Under his plan, controlled research would be under the guidance of the blood derivatives committee of the Red Cross Advisory Board on Health Services.

What's more, the health departments of some states would be very dubious agencies to serve in accrediting blood banks. Much more can be expected from the American Association of Blood Banks. Through inspections, it will raise standards for blood banks just as the American College of Surgeons

...a serious complication... amenable to therapy



"It cannot be overemphasized that malnutrition exists coincident with a primary disease, that malnutrition is a serious complication and is amenable to therapy.... As these patients are in such great need of protein, a therapy of overfeeding is indicated."[1]

Essenamine®

Palatable Easily Assimilated Protein Concentrate for Oral Use

Success with Essenamine—as the principal ingredient of a high protein diet—is probably due to four factors

1. High concentration of proteins;
2. High content of essential amino acids, that is, high biologic value;
3. Lack of any pronounced taste, so that it can be incorporated in large quantities in other foods that have a pleasant taste;
4. Limited solubility . . (which) apparently minimized the concentration of amino acids in the small intestine at any one time, so that the sense of fulness was postponed and the tendency to diarrhea . . . did not occur.[2]

Essenamine is supplied in 7½ and 14 oz. wide-mouth jars

Attractive Essenamine Recipe Book sent on request. Specify number of copies wanted.

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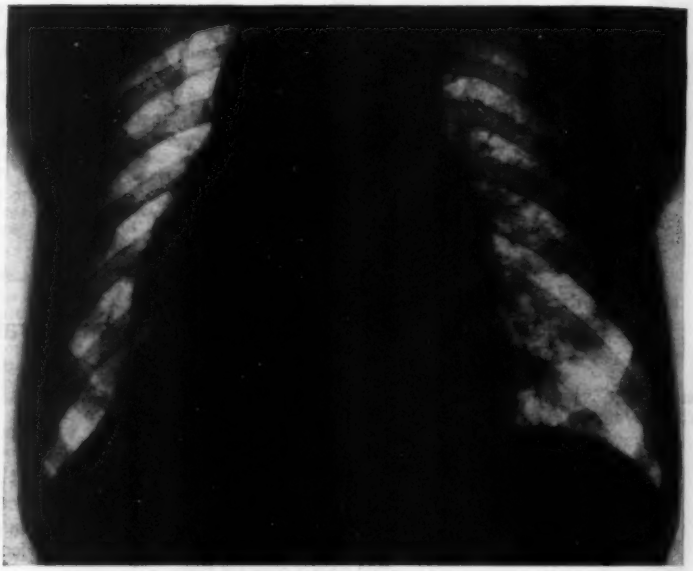
ESSENAMINE, trademark reg. U.S. & Canada

1. Sprinz, H.: *Med. Clin. North America*, 30:363, Mar., 1946.
2. Kozoll, D. D., Hoffman, W. S., Meyer, K. A., and Garvin, Thelma: *Arch. Surg.*, 53:683, Dec., 1946.

eyes *that see into*



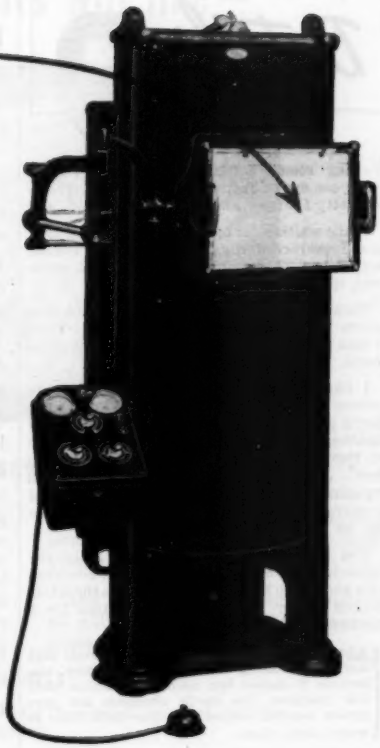
With the eyes of x-ray the physician looks deep into the secrets of the heart. From position, size and contour, from calcification and from abnormal motion, he makes his skilled interpretation. But still there are secrets. . . .

In the coming tomorrows will those mysteries remain? Developing ever more useful apparatus is General Electric — leader in x-ray. What does a leader do? *A leader investigates.* In the General Electric Research Laboratory the whirling electrons of the G-E Betatron are spinning a new skein of knowledge.

A leader pioneers. From General Electric X-Ray came the million-volt x-ray therapy unit, the Coolidge hot cathode tube, and the Coolidge rotating anode tube. *A leader makes tradition.* Born in the year of Roentgen's discovery, General Electric X-Ray grew as the art of x-ray grew.

General Electric leadership holds a meaning for you. It is assurance that any apparatus bearing the G-E emblem is the finest you can own.

the heart



G-E Vertical Roentgenoscope—for easier, more efficient vertical fluoroscopy

The G-E Vertical Roentgenoscope gives you everything you need for vertical fluoroscopy. The sturdy G-E transformer will supply dependable power within its rating of 10 ma at voltages up to 90 kvp.

An orthodiagraphic attachment makes heart-size examinations a simple procedure. The screen remains fixed while the x-ray tube moves. Lead pellet in center of beam helps you make accurate heart-size tracing.

Compact. The G-E Vertical Roentgenoscope occupies an area less than three feet square; can be tucked into a corner of your office.

Convenient. The easy-to-use control may be mounted to either the right or the left of the Roentgenoscope. You can adjust its height and angle to your convenience.

Time-saving. One finger-tip control moves screen and tube vertically or laterally in unison; regulates size and shape of diaphragm aperture. Screen swings back easily for faster positioning of your patients. And once the patient is in place, the 14-inch lateral travel of the screen saves repositioning.

For fluoroscopy that General Electric has worked hard to make easy — investigate the G-E Vertical Roentgenoscope. An illustrated folder will be mailed on request. No obligation. Write General Electric X-Ray Corporation, Dept. G-16, 4855 McGeoch Ave., Milwaukee 14, Wisc.

GENERAL ELECTRIC

• General Electric X-Ray Corporation manufactures and distributes x-ray apparatus for medical, dental and industrial use; electromedical apparatus; x-ray and electromedical supplies and accessories.

X-RAY

has raised standards for hospitals.
Marjorie Saunders, Sec.
Am. Assn. of Blood Banks
Dallas, Texas

Degrees

Hugh J. McDonald's remarks, quoted from the Journal of Higher Education in your article entitled "That Doctor's Degree," constitute a gross misrepresentation. He states: "Doctor of Surgical Chiropody, in eighteen months to three years, the minimum entrance requirements being the same as in the chiropractic field."

There are six accredited chiropody schools in the United States. One requires a high school education, four require one year of college work, one requires two years of college work. In five schools the length of the course is four years; the other has a three-year course.

Howard Joseph
New York, N.Y.

. . . The Degree of Doctor of Osteopathy requires at least two years of college work as a prerequisite, not one year as stated . . .

Ira C. Rumney, D.O.
Ann Arbor, Mich.

. . . Only during the war emergency were any degrees for Doctor of Dental Surgery granted in three years. All dental schools, except perhaps one, require a minimum of two years of college work and four years of professional school.

James W. Hardin, D.D.S.
Cadiz, Ky.

Widening the usefulness of Penicillin in Therapy

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Available to members of the medical profession through the pharmaceutical companies is a recent contribution to penicillin therapy, Procaine Penicillin G Crystalline — Pfizer.

By the development of this relatively insoluble penicillin salt, Chas. Pfizer & Co., Inc. has furthered better medication through research, and has widened the potential usefulness of penicillin as an important therapeutic agent.

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The new salt is supplied in bulk in its dry crystalline form (sterile) and also in sterile suspensions suitable for intramuscular injection. Chas. Pfizer & Co., Inc., 81 Maiden Lane, New York 7, N. Y.

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(Representing 43% Salicylic Acid and 3% Iodine in Calcium-Sodium Phosphate Buffer Salt Combination)
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A decidedly satisfactory companion medication to RAY-FORMOSIL, hastening the onset of the latter's favorable effects. RAYSAL'S salicylate component is widely acknowledged to be of almost specific usefulness in the treatment of certain rheumatic ailments. . .the addition of succinic acid (a normal constituent of body tissue) counteracts, in most instances, the toxic effects so often encountered when salicylates are employed in prolonged treatment. Try RAYSAL with SUCCINATE in your next case of rheumatism or arthritis... write today for a professional sample and literature.

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Ray-Formosil for intramuscular injection is a clinically proved, effective treatment . . . for Arthritis and Rheumatism. It is a non-toxic and sterile, buffered solution containing in each cc. the equivalent of:

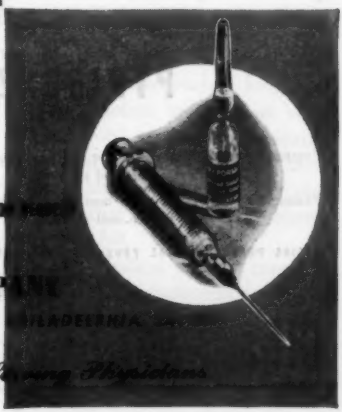
FORMIC ACID 5 mg.
HYDRATED SILICIC ACID 2.25 mg.

Descriptive clinical literature will be furnished upon request.

Supplied in: 1 cc. and 2 cc. Ampuls

73% BENEFITED

In one series of clinic-treated cases of atrophic, hypertrophic and mixed arthritis—with best results in hypertrophic and fibrositic types.



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Sidelights

Health Counselor

What's the difference between "family doctor" and "general practitioner"?

More than some people think. Experts on G.P. problems have noticed that medical men are often willing to become the former without becoming the latter. The family doctor must, of course, know the fundamentals of all medical specialties. But unlike a number of G.P.'s, he makes no attempt to practice all specialties. Instead, he may limit his field to internal medicine. When families under his care need services outside this field, the health counselor refers them to another doctor.

It's doubtful that rural areas will ever be able to get along without all-around G.P.'s. But in many urban regions, it's possible that the non-G.P. family doctor may be one answer to the need for improved medical service.

Shell Game

When England rings up the curtain this month on its new national health plan, many a U.S. practitioner will be listening for audience reactions from the British Isles. One hint of what he may hear stems from the remarks of an Englishwoman quoted recently by Sir William Darling.

Said the woman: "This nationalization is a queer thing. We own the Bank of England now, but I am no better off. We own the coal mines, and I have less coal than I used to have. We own the railways, yet I cannot get a seat in a train. This socialism! The more we own, the less I've got."

A cheery thought for the people who now find that they "own" British medicine!

Costly Chit-Chat

Trouble-shooters in the field of legal medicine discovered long ago that malpractice suits often stem from doctors' unthinking remarks about their colleagues. Check over the latest studies on this matter and you find that the situation hasn't changed a bit.

As one medical society committee puts it: "Unwarranted, irresponsible, or thoughtless criticism of other members continues to be the

largest single source of inspiration for malpractice actions."

Which indicates that we're not making much progress. It's worth noting that until we do, we're helping to peg malpractice insurance rates at their present high level. Avoiding snap judgments of our colleagues can, in the long run, save us a pretty penny.

Low Overhead

Early returns from the Sixth MEDICAL ECONOMICS Survey suggest that some physicians lack a true picture of where they stand financially. Most frequent evidence of this is a tendency to underestimate overhead.

Among the private practitioners who returned this magazine's questionnaire were some who reported their net income as being around 75 per cent of their gross income. This of course meant that 25 per cent was spent for professional expenses.

Since a 25 per cent overhead is possible but not probable, all survey cards bearing such a low figure were checked closely. It wasn't hard to find the answer: Most of the doctors in question had simply neglected, when figuring overhead, to include all the items that belong there (*e.g.*, depreciation on equipment).

Albeit unintentionally, these physicians are kidding themselves about the size of their net incomes. They are also paving the way for budgetary troubles later.

Use the *SAFEST* antihistaminic *first*

Neohetramine

"Clinically, Neohetramine has an advantage over all other antihistaminics investigated, in that it is extremely well *tolerated*, and may often be used successfully in patients who are unable to take other drugs of this series because of unpleasant side actions."

Friedlaender, S., and A. S. Friedlaender, American College of Physicians, Milwaukee, 15 Nov. 1947.

Neohetramine is by far the safest antihistaminic. It maintains a high average of effectiveness and causes the fewest side reactions. Only 1 per cent of 1000 patients had to discontinue treatment.

Trial-and-error is the watchword in prescribing antiallergic drugs. Idiosyncrasies of the patient make it difficult to foresee which antihistaminic will afford the greatest symptomatic relief—or cause the lowest incidence of side effects.

Therefore—try the *safest* antihistaminic *first*.

Dosage: 50 to 100 mg. three or four times a day, preferably after meals and at bedtime.

25, 50, and 100 mg. tablets, bottles of 100 and 1000.

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diarrhea of newborn

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"sulfosuxidine" suspension with pectin and kaolin

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Mortality in the neonatal group of patients has shown a persistent upward trend,[1] and may "*be attributed in large measure to the prevalence of epidemic diarrhea of the newborn infant.*"[2] Overcrowding and understaffing of hospital nurseries are important contributing factors, and until these war-induced conditions can be corrected, particular emphasis must be placed on isolation and prompt control.

CREMOSUXIDINE,* a palatable, highly effective new preparation developed by Sharp & Dohme, aids management of diarrhea regardless of its cause. A delicious, smooth, chocolate-mint flavored suspension of succinylsulfathiazole (10%), pectin (1%), and kaolin (10%), CREMOSUXIDINE acts promptly to consolidate stools, eliminate products of putrefaction, soothe inflammation, and check bacterial infection.

Dosage: Infants and children in proportion to adult dose of 2 to 3 tablespoonfuls 4 times daily. Supplied in pint bottles. Sharp & Dohme, Phila. 1, Pa.

*Registered trademark of Sharp & Dohme

1. Frant, S., and Abrahamson, H.: *Brennemann's Practice of Pediatrics*, 1:22:22, 1945.
2. Blattner, R. J.: *J. Pediatrics*, 32:220, February, 1948.

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96-Hour Penicillin Blood Levels with

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Here is a revolutionary improvement in repository penicillin formulations: *a single 1 cc. injection (300,000 units) produces and maintains therapeutic blood concentrations for 96 hours in 90% of patients.* This outstanding achievement does away with the need for every day injections in repository penicillin therapy; the recommended dosage of a single 1 cc. injection *every other day* is judged to be adequate for the majority of clinical purposes.

In Addition

Flo-Cillin "96" is a stable, always fluid suspension which doesn't "settle out." No extemporaneous mixing or prolonged shaking is required. A uniform dispersion of penicillin is assured in each and every dose.

FLO-CILLIN "96"

Procaine Penicillin G in Oil
(*300,000 units per cc.*)
with Aluminum Monostearate, 2%

Available NOW from your usual source in vials containing ten 1 cc. doses; in a sterile disposable package containing a 1 cc. cartridge and one B-D Disposable Cartridge Syringe; and in 1 cc. cartridges alone for use with the B-D* Metal Cartridge Syringe.*

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Here, too, are stamina, compactness and the remarkable versatility of 33 proven technics, as acclaimed by all who use the Hyfrecator.

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A NEW CHAPTER IN ANALGESICS

For more than a hundred years, morphine has had no peer in relieving pain; its usefulness as an analgesic overshadowed its unfavorable aspects. In 'Dolophine Hydrochloride' (Methadon Hydrochloride, Lilly), physicians now have another remarkable pain-relieving drug which is effective both orally and hypodermically.

Under many circumstances, 'Dolophine Hydrochloride' is equal to or actually excels morphine in therapeutic effectiveness. Clinically, 10 mg. of 'Dolophine Hydrochloride' provide the same degree of analgesia as that obtained with 15 mg. of morphine, but with less euphoria and sedation. The ability of 'Dolophine Hydrochloride' to relieve spasm of the urinary bladder and to depress the cough reflex is especially noteworthy.

On narcotic orders, 'Dolophine Hydrochloride' is available as:

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Ampoules 'Dolophine Hydrochloride,' 10 mg. per cc., 20 cc. (No. 435)
Tablets 'Dolophine Hydrochloride,' 2.5 mg. (No. 1711)
Tablets 'Dolophine Hydrochloride,' 5 mg. (No. 1712)
Tablets 'Dolophine Hydrochloride,' 7.5 mg. (No. 1713)
Tablets 'Dolophine Hydrochloride,' 10 mg. (No. 1730)
Syrup 'Dolophine Hydrochloride,' 10 mg. per 30 cc. (No. 116)

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Editorial

That Extra Dividend

• The physician who first thought of using a lollipop for a tongue depressor not only made a lot of friends among his juvenile patients. He also set an example for dealing with patients of all ages:

If you can give an extra dividend at little or no extra effort—why not do it?

Today, when many of us are shouldering heavyweight practices, the idea of giving something extra for the patient's money may seem unrealistic. Yet, actually, that something extra may take only a dash of ingenuity and a thin slice of your time.

Most anyone's office routine will show opportunities for extra service. Maybe a simple change in appointment spacing—so simple that it may have been overlooked—will cut down patients' waiting time. Or the dividend may take the form of a reception-room writing desk, fully equipped for quick correspondence, to make the waiting time seem shorter.

Perhaps a more flexible method of setting fees would help patients of modest means. (It could also stimulate collections, for patients respond best when charged what they can afford.) Another extra for debt-pressed patients—and a useful nudge for collections—may be an offer to accept installment payments. Without burdening your office staff unduly, such installments make it easier for selected patients to pay the freight.

These schemes are only samples. They're not new. But they show what can be done by evaluating a practice with an eye to rendering greater service.

Even the simplest dividend—a box of facial tissues in the women's dressing room or a set of personalized instructions for convalescents—is likely to pay off in two important ways:

(1) Better service means better satisfied and hence better paying patients.

(2) Your practice gains a substantial degree of added economic stability.

Giving patients that extra something today is hard-to-beat insurance against recession tomorrow. More often than we think, it's the lollipops that count.

—H. SHERIDAN BAKETEL, M.D.

What Makes a Medical Program Click

Columbus academy formula for provocative meetings packs house regularly

● When more than half the physicians in a county attend a medical meeting, that's news. When a medical society maintains that batting average month in and month out, it's phenomenal. Clearly, the program committee has something on the ball.

Throughout last year the Columbus (Ohio) Academy of Medicine chalked up a better-than-50-percent attendance record. Under a wide-awake program chairman, Dr. Thomas E. Rardin, it put on programs that consistently aroused the interest of both G.P.'s and specialists—programs that moved with the precision of a sixteen-cylinder engine.

From the audience standpoint, it looked like a smooth and effortless performance. Smooth it was, but hardly effortless. The project purred in high gear only because of meticulous planning and organization.

The task was to enlist gifted speakers, to select interesting topics, to release attention-getting publicity, and to think of all the little details that make for red-letter programs. As a starter, the committee met the summer before and selected a roster of desired speakers. To make this honor roll, the speaker not only had to have a reputation for technical expertness; he had to be recognized as a topflight teacher as well. Most invited guests were "auditioned" by members of the committee. No one was called in for a tryout, of course. But in most cases, some responsible official of the academy could say he had heard the proposed guest and knew that he had good platform presence and delivery.

Topics were chosen adroitly to appeal to all doctors, regardless of specialty. This was less easy than it sounds, since subjects of major importance often have limited audience appeal. The committee realized that it is not enough to have an intrinsically interesting topic; it must be presented in eye-catching, ear-catching form. Thus, instead of dry-as-dust titles like "Indications for Roentgenotherapy" and "Radical Surgery," the committee worked out titles like "Will X-ray Therapy Help My Patient?" and "Operating the Inoperable."

Meetings were advertised to the profession through posters, post-

cards, mimeographed letters, and bulletin board announcements in hospital staff rooms. All were written in a provocative style that whetted the reader's appetite. Instead of solemnly offering a lecture on psychotherapy, for example, one set of letters called attention to the frequency of emotional complaints in daily practice. ("How often have you wondered why you became a

[*Continued on* 91]

1947 Program of the Columbus Academy of Medicine

"Advances in Surgery Applicable to Office Practice." Drs. D. L. Davies and R. W. Zollinger of Columbus.

"Office Detection of Premalignant States." Drs. Warren Harding, William Morrison, Edwin Stedem and Horace Davidson of Columbus.

"Operating the Inoperable." Dr. Alexander Brunschwig of Chicago.

"A Doctor Talks Nutrition." Dr. Fredrick J. Stare of Boston.

"Physical Medicine in Today's Practice." Dr. S. G. Gamble of Columbus.

"Diseases of Adaptation." Dr. Hans Selye of Montreal.

"Skin Manifestations of Internal Disorders." Dr. A. C. Curtis of Ann Arbor, Mich.

"Fatigue–Exhaustion–Nerves." Dr. Benjamin Balser of New York City.

"Alcoholism." Dr. Harry M. Tiebout of Greenwich, Conn.

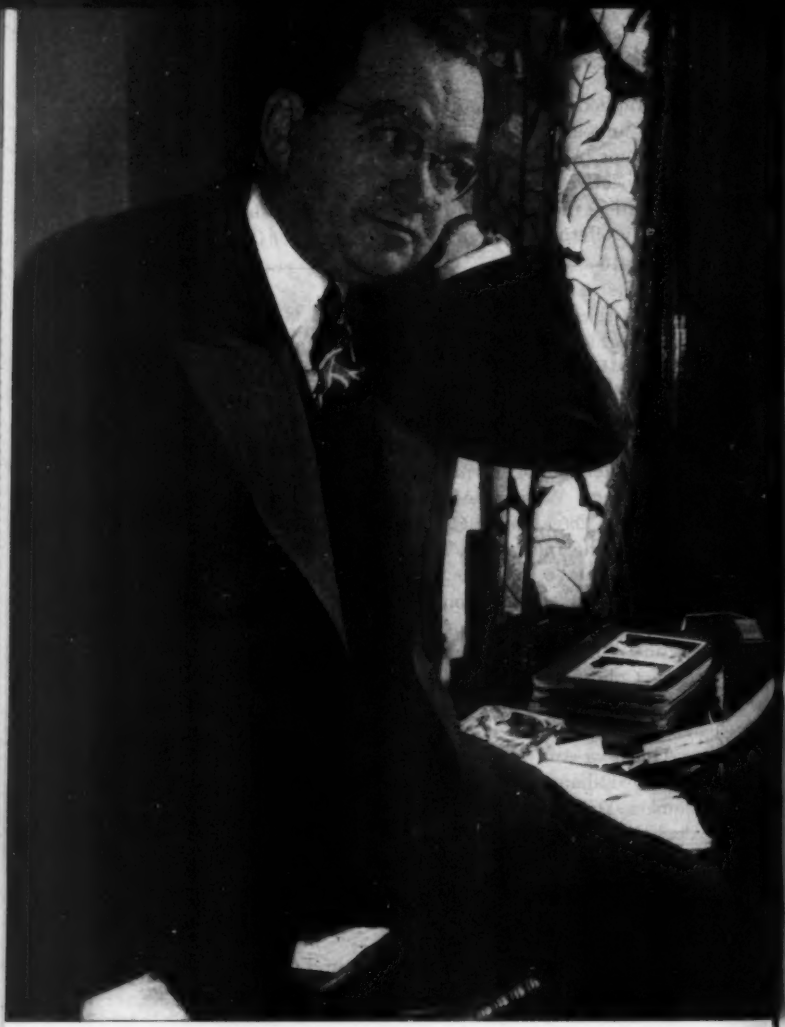
"New Horizons in Medical Practice." William Alan Richardson, Editor of MEDICAL ECONOMICS.

"What's New About Hyperglycemia." Dr. Jerome Conn of Ann Arbor, Mich.

"Diagnostic Nuggets." Drs. G. D. Kirk and O. F. Rosenow of Columbus.

"Diagrammatic Psychiatry and Social Medicine." Dr. George H. Preston of Baltimore.

"Thyrotoxicosis." Dr. Cyrus C. Sturgis of Ann Arbor, Mich.



BRIGHT EYES of Ernest Boggs pick out each bit of office routine that doesn't yield full service for the patient, full payment for the doctor. He's handled business affairs for as many as sixty-five doctors at once.

his specialty . . .

Minding the Doctor's Business

Meet Ernie Boggs, whose ideas on running a medical practice have helped his M.D.-clients to heaping portions of success

The marriage between medicine and its business details has seemed, to some budding M.D.'s, about as blissful as a shotgun wedding. Twenty-three years ago, a jaunty little man named Ernest L. Boggs discovered that doctors would pay for advice on improving the state of the union. Since then, some 300 medical men have practiced what Boggs preaches. They have watched their incomes tilt upward an average of 20 per cent within six months as patients got more and better service.

Consider, for a sampling of this therapy, the time two Detroit pediatricians were stumped. They worked out of the same office; they saw the same number of patients; they charged the same fees; they sent out bills through the same secretary. Yet, somehow, one physician was banking 20 per cent more than his colleague. What was wrong?

To find out, they decided to call in Boggs. Next day the chunky Scotch-Irishman breezed into the office, disappeared behind a flurry of records and account cards. An hour later, he bobbed up triumphantly with the answer. "Look at these addresses," Boggs told the short-end M.D. "Lots of them are in the poorer sections of town; yet you've been charging those patients your standard $5 a visit. They just haven't been paying it."

Fees That Fit

The physician began tailoring his fee to the patient's standard of living—and, within two months, his total take jumped 15 per cent. Both doctor and patient benefited. So, of course, did a third party named Boggs, who reaps an estimated $45,000 a year from this sort of managerial magic.

If it were possible to cross-breed Dale Carnegie with an International Business Machine, Ernie Boggs is what you'd get. At 53, he has few peers as an efficiency expert around the medical office. By setting up sound business procedures, by taking the dead weight of routine off the doctor's shoulders, by project-

ing the bedside manner into the office, he puts a distinctive stamp on clients' practices. They pay for it to the tune of $75-$450 a month. But for every dollar paid the effervescent Mr. Boggs, the average practitioner gets back $8-12 in new income.

This office alchemy is accomplished unobtrusively, for Boggs himself is seldom in evidence. His natural habitat is an 8′ x 10′ cubicle crammed with dictaphones, intercom equipment, a flashing-light signal system, mail chutes, and all the devices you'd expect of an efficiency expert. Boggs even talks efficiently, in clipped sentences that start with verbs and leave out waste words. Offsetting this brass-tacks mien is his well-fed, jocular appearance, his contented-cat smile, and his man-of-distinction garb. It's not flashy, but as one client puts it, "You'd get the same effect if he wrapped himself in Government bonds."

Dividends for M.D.'s

Boggs' clients pay for results, though—not trimmings. Most have gotten more than their money's worth. One young surgeon took in exactly $4 his first month under Boggs' tutelage; nine years later he was in the $60,000-a-year bracket. Boggs would be the first to admit that the doctor's skill had something to do with it; but he leaves no doubt that his management played a part, too.

Or take another Boggs transformation: A man with an on-paper practice of $30,000 was collecting only 68 per cent of his bills. Without recourse to high pressure or low schemes, by going at the records rather than at the debtors, Boggs sent the man's collection percentage zooming to 99.

Vacation That Pays

Then there's the middle-aged G.P. who was grossing $5,000, with 50 per cent of his bills uncollected. He didn't even know the full name of many of his patients, much less how much they owed him. Boggs sentenced him to a much-needed vacation. Engraved announcements reported that the doctor was off on a holiday, would return in a month. He got back to find his office overflowing with patients. More important, his accounts were in order and his billing system on a Boggsian basis—to the tune of $11,000 that year.

How does Boggs do it?

That's what young Doctor Blank wants to know when he first hears about Boggs. Blank has just completed his residency, has some modest plans for practicing internal medicine, and is looking for office space. A colleague can't help him, but suggests Boggs. "What does he do?" Blank asks curiously.

"Well," says the other, "he's got ideas about everything except medicine itself. He sets up a financial program, so you'll have enough to

start practice right. He helps you pick an office, lay it out, equip it, hire the people to run it. He gives you ideas on meeting the public, on getting known among colleagues. Best of all, he shows you how to scale your fees properly."

A pretty tall order, Doctor Blank thinks. But he knows his own blind spots. So he gives Boggs a call. Typically, Boggs spends a day or two checking on his training, background, and personal qualities. If he then wants Blank as a client, Boggs says: "Why not give it a try for $75 a month?" They don't sign any contract, but it's a deal.

First on the docket is working capital. One of the important items in Boggs' repertory is a speaking—and borrowing—acquaintance with bankers. Vouching personally for his client, Boggs arranges a $4,000 loan for one year (actually, it's repaid within six months). Then the sharp-eyed Mr. Boggs begins scouting around for an office.

"But this is much too large," objects the doctor when Boggs discovers a suite that looks promising. "I won't have half enough patients to fill those treatment rooms." But Boggs knows how a well-managed practice can mushroom and sells the idea. Professional equipping he

[*Continued on* 122]

"Forget it, Doctor . . . professional courtesy!"

Boomerang in New Zealand

Doctors and patients have had seven troubled years under the Government's medical plan

● After seven years of charge and counter-charge, the medical profession and the Government of New Zealand have declared a truce. Representatives of both sides are now meeting in peaceful session. Their aim: a revision of the medical program that has been so highly touted by U.S. proponents of a Wagner-type health plan. New Zealanders will know shortly what changes are to be made.

The move for joint action started when the administration finally realized that a capitation scheme, or even a fee-for-service system, will not work when physicians think it unfair. The doctors' goal in the current conference is the type of fee-for-service system that will preserve private practice. They recognized long ago that social security was a fixture under the Labor regime. They now seek to avert a complete-

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**New Zealand's health security program has been hailed as a shining example by those in the U.S. who favor tax-paid medical care for everyone. But what do New Zealanders think of their scheme? To get an objective answer, a reporter for this magazine was commissioned to interview a cross-section of New Zealand's patients, doctors, and Government heads. Here is his on-the-spot report.*

MODERN port of Auckland City is far cry from tropic cove explored by Captain Cook. Only 5 per cent of New Zealanders are native Maoris.

---

ly socialized medical care system.

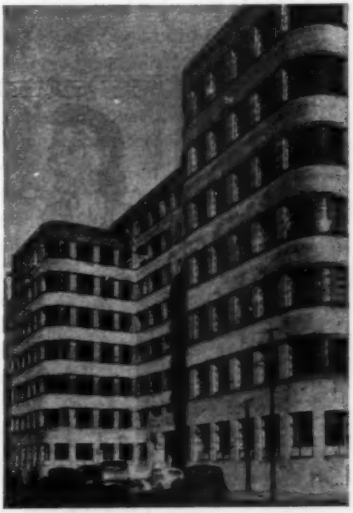
The Government didn't bother to consult the doctors when, in 1941, it launched the medical part of its social security program. It rejected the profession's advice to postpone the program until physicians on war duty could return to help carry the load of free service. In the four years that followed, the demand for medical services tripled. Patients queued up outside surgery doors and medical appointments were booked four months in advance. The depleted profession heard the Government accuse it of avoiding responsibility. But the doctors were too tired to reply.

By 1947, with the profession back to full strength, the Government changed its tune. Laborites squirmed when they saw that the bill for tax-paid medical services had risen from less than $8 million in 1942 to more than $20 million in 1947. Publicly, the politicians still promised unlimited benefits to the voters. But in careful asides, they asked the doctors to reduce the bill by restricting services.

Doctors would have none of this. Nor did they appreciate other grandiose schemes the administration had made for them.

The original plan called for fixed panels of patients, with the doctor receiving about $2.50 a year for each person on his list. Transfer was possible but restricted. The British Medical Association in New Zealand viewed this as a political set-up that would leave doctors holding the bag: The Government, which had accepted an unlimited sickness insurance risk in return for a sizable tax premium, "was attempting to transfer the risk to doctors at a fixed fee."

Equally unfair, thought the BMA, was the creation of fixed panels of patients while one-third of the profession was still in service. What's more, said the profession's



JAM-PACKED hospitals are the rule in New Zealand since beginning of the free medical service plan.

spokesmen, the panel system would restrict entry into the profession to those who could afford to buy a practice.

For these reasons, the BMA advised doctors not to enter into capitation contracts. Only a minority of pro-Laborite physicians refused the advice, and they soon found working under a capitation scheme demoralizing. Some doctors were charged with unethical canvassing for large panels (rumored to contain up to 20,000 patients). Some were criticized for allegedly avoiding contracts with chronics and for excessive hospitalizing of difficult cases.

Added to these has been the continuing charge that the system results in "mutual irresponsibility" on the part of patient and doctor. The complaints have had a telling effect, and the total demise of the capitation plan is expected soon.

When the majority of doctors refused capitation payment, the administration set up an optional fee-for-service arrangement. Under it, the patient signs a form that the doctor sends to the district medical office. The physician is then paid from social security funds at the rate of $1.25 for a week-day visit, $2 for night and week-end visits. He gets an extra 25 cents for every five minutes over a half hour that he spends with each patient. Coun-

"You're my first patient—mind if I rummage around a bit?"

try doctors are allowed mileage at the rate of 20 cents for each mile traveled.

While these were substantial concessions, the BMA still recommended non-participation. It objected to a third party mixing into the doctor-patient relationship — especially when the third party was a Government that paid low rates for the services rendered. The BMA predicted that the fixed fee would mean quantity rather than quality service.

Only a few practitioners saw enough advantages in the scheme to participate. Ninety-five per cent of the profession held out for a better arrangement. They forced the Government to accept the "refund" system. Under it the patient pays the doctor his regular fee (usually $1.75), then sends the receipt to the post office for a $1.25 refund. A variation used by some doctors is the "token" system, by which the physician collects 50 cents from the patient in cash, then makes a claim for $1.25 to the district health office.

In neither case are the parties to the plan satisfied. The Government wails that its campaign promises of free medical service aren't being met; it grumbles that the service is too costly, too cumbersome to administer on a fee-for-service basis. The Laborites eye with pangs of conscience the heightened medical incomes that have resulted in some cases. Patients kick at the red tape that tangles their refunds; some accuse doctors of being reluctant to give week-end or night service.

But the chief drawback of the entire plan, according to the public, is its failure to provide for the crippling expenses of major surgery. The benefits the average patient gets in return for his heavy tax payment are limited to routine treatment from his doctor, hospitalization in an overcrowded public institution, and free pills from his pharmacist.

To the physician, the chief annoyance is the shopper-patient. He goes from doctor to doctor, leaving a maze of official forms in his wake, until he gets the treatment he's read about in his favorite magazine. Other patients burden physicians with tie-in requests: a certificate for added food rations; an excuse for an extra kilo of petrol. Nuisance visits by people with imaginary ailments also bog down the doctor's practice. As a result, it is said, the

* HANDITIP *

Fog Lenses

Sudden fogs won't hamper your driving if you have handy a pair of amber-colored, plastic headlight lenses. They're easy to clamp onto your regular car lights. Your glove compartment will hold them when they're not in use.

* * * * *

standard of a number of medical men have slipped.

The profession is still chafing under the provision of the act that prevents doctors from suing in court for debts that exceed the fixed $1.25 fee. Even though physicians don't often use the courts to collect fees, they resent this short-circuiting of their civil liberties. Because of it, the profession has refused to accept full responsibility under the act. Administrative positions that were supposed to have been filled by doctors are still vacant.

Serious criticisms have also been leveled at the free-pharmaceuticals section of the social security program. For this service in 1947, the Government paid more than $4 million. (In 1943, the bill was less than $2 million.)

The doctors were immediately accused of over-prescribing. The BMA countered that the Government itself was at the root of the inflated pharmaceutical bill because:

¶ It enabled patients to get drugs of almost unlimited character entirely without cost to themselves.

¶ It encouraged self-prescribing by placing on the free list all the commonly used items, such as aspirin and tonics .

The BMA also pointed out that while pressure groups had led the Government to wipe out almost all restrictions on the list of free pharmaceuticals, the Minister of Health expected doctors to refrain from prescribing many of the items allowed. Indeed, said the BMA, he reproached the profession continually for its allegedly free-and-easy prescriptions. To help solve the problem, the BMA has asked repeatedly that the patient be required to pay part of the cost of his medication.

These and other charges and criticisms are on the agenda of the conference now nearing an end. Even if they are all resolved, the outlook for the profession in New Zealand is still bleak. The social security program has inflated the demand for medical practitioners. It has led to an over-staffed profession. Only as long as the social security fund is maintained at one-third of the nation's budget, can the M.D. increment be supported.

Looking ahead to the next economic recession, New Zealand doctors find themselves faced with an ominous question: When budget cutbacks come, what will happen to the overcrowded profession that the Government socializers have created?

—E. HORACE SIMS

* HANDITIP *

Magazine Dispensers

For your patients' convenience, put reception room reading matter at their finger-tips rather than half way across the room. Judiciously located occasional tables afford the best means for turning this trick.

Open Letter to An Obstetrician

● Dear Doctor:

The male infant you delivered into this world Friday is temporarily asleep, temporarily fed, and temporarily dry. My husband (that disheveled totem-pole standing in a circle of cigarette butts outside the delivery room) joins me in gratitude to you for the aforementioned infant and for your kind care. We enclose our check.

Before we terminate our association, though, I should like, most humbly but most emphatically, to submit to you a list of suggestions. These, I fervently hope, will be put into practice before the next time I bound into your office, specimen in hand.

Item 1: When your cheery assistant has supervised my unrobing and stretched me in the approved position on your examination table, when I am staring at the ceiling and doing my best to seem blase, please don't appear at the door with a wide smile, rub your rubber gloves together, and say, "Well, Mrs. Brown, what can we do for you today?" What do you think you

[*Continued on* 109]

Designs by John Shea
Sketches by Samuel Tapper

PRIVACY FOR THE WAITING PATIENT

● Sick people, it goes without saying, are in no mood to be sociable. Nevertheless, the furniture arrangements in a good many reception rooms all but cram sociability down the patient's throat. Face-to-face seating or a three-men-on-a-couch motif can give the average person

an uncomfortable time of it while he waits to see his doctor.

Shown on these pages are some new ways to exterminate such bugs in reception room layout. End tables, plant boxes, open partitions, and low glass panels are used to divide up the space into semi-private sections. Back-to-back seating helps banish that stared-at feeling. The net result is a welcome touch of seclusion for people who have to wait.

Though the stress is on individual seating, these designs make maximum use of available floor space. What's more, the effect of compartmentation is achieved without hampering the room's lighting or its decorative unity.

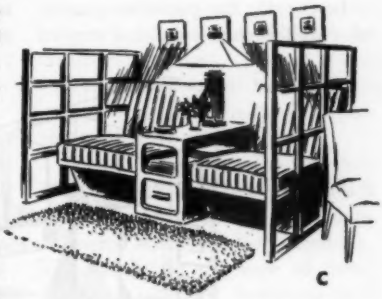
Let's see how all this is accomplished:

Cut A shows a "center island" that is well suited to large reception rooms. It seats eight persons in uncrowded comfort. Reading matter and ashtrays are placed within easy reach of each patient. Two reading lamps provide illumination for all eight.

Not only does this design keep reception room occupants out from under each other's gaze; it also puts to efficient use an area that in some offices becomes a sort of "no-man's land."

A simple, side-of-the-room arrangement is sketched in cut B. It provides individualized, back-to-back seating in little more space than a three-seater couch would oc-


B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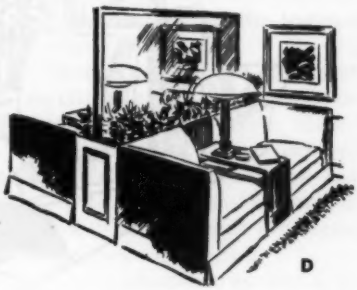

D

cupy. End tables adjoin each seat, so that patients won't have to wander about in search of new magazines.

Cut C shows how low, latticed screens can be used to divide your waiting room into sections. They provide just enough compartmentation to give patients a sense of seclusion. The cross-hatched wood construction is inexpensive yet decorative, interferes with neither air circulation nor your office lighting. A fitted throw rug helps to build up the impression of a separate section.

In cut D, the partition consists of a well-stocked plant box topped by a low, plate-glass mirror that reflects the greenery. The sectional chairs shown are of standard make, can be joined together to form two-seater couches if desired. Their high sides are an extra contribution to patient privacy.

Another type of partition you may find useful is the "egg crate" variety, illustrated in cut E. Openings in the partition can be used to hold reading matter or flower bowls. Two built-in lamps contribute to a design that is both attractive and practical. Individual tables separate the two seats on each side of the partition.

E

Your Assignment in World War III

Part 2 of a report begun last month on the basic thinking of medicine's war planners

• June 1948 saw the framework of a plan for wartime civilian medical care finally beginning to take shape. One of its chief architects, Dr. Perrin Long of Baltimore, medical consultant to the Department of Defense, reported that these principles were being used as guides:

1. In case of war, most doctors should be free to concentrate on the sick and wounded. A few would have to do administrative jobs; but radiological safety, for example, should be left to physicists, sanitation to engineers.

2. Small, highly mobile teams of physicians and medical auxiliaries should form the backbone of the civilian medical care system. Teams should be geared for specific types of missions.

3. Civilian organizations such as medical societies, the American Red Cross, and other agencies should take the responsibility for assembling and training such teams, with the ARC in charge of lay personnel.

Barring major changes in these principles, said Doctor Long, physicians could anticipate the following developments in the event of a national emergency:

About half of all practicing medical men would be withheld from the armed forces. Most G.P.'s would be assigned to units that would give first aid to civilian casualties. Most specialists would be detailed to surgical, psychiatric, and other "special mission" units that would staff the treatment centers. These teams would be transferred from area to area to cope with the heaviest casualty loads.

Special training for civilian M.D.'s would put heavy emphasis on the care of casualties from high-explosive and incendiary bombing, less weight on the care of those from atomic and bacteriological warfare. Intensive courses conducted by medical schools and medical societies would be planned and set up with the help of the National Research Council.

Medical supplies and equipment for civilian medical teams would be handled by military depots. Shunting responsibility for procurement and storage onto the Army and Navy would avoid civilian stockpiling of items that might deteriorate before they were needed.

—EDMUND R. BECKWITH JR.

No fumbling for patients' records with a one-handed "visible" file.

What's New in Filing Equipment

● A beet just removed from boiling water is what your secretary's face looks like as the harassed girl drops a case-history card on your desk. "What's the matter?" you ask. "Oh, it's that blasted filing cabinet," she says testily. "I have to put on a tug-of-war to get the drawer open. And it's jammed so full I need a writ of habeas corpus to get a record card out where I can see it."

Which may mean that your filing system is due for a face-lifting. If so, the prospects are good: Filing equipment of pre-war quality is back on the market in plentiful supply. Prices are up, but not prohibitively so. And a variety of new designs—plus the consultation services offered by the larger manufac-

turers—means that you can tailor your equipment to your own office needs.

Quality is more than skin deep in Grade A equipment. In good letter-file cabinets, for example, you'll get oversize steel frames that cheaper files never have. You'll get fittings of solid aluminum, bronze, or brass, instead of plated steel. Finish will be baked on and durable.

Prices for a good letter cabinet range from $45 for a two-drawer, desk-high model to about $78 for a tall, five-drawer affair. Light-gray and green are the standard finishes, but you can get most any color by paying about 20 per cent more.

Maybe you'd rather keep your record and financial cards atop your desk. In that case, look over the junior-size cabinets designed for 4" x 6" or 5" x 8" cards. They range in price from about $6 for a one-drawer model to about $22 for a four-drawer file.

Perhaps the handiest of all systems is the "visible" file: You don't have to take patients' cards out of the file before you can read them. Simplest form is the "book" unit. When you open it up bookwise, the names on all its record cards are spread before you. A forty-two-card book costs about $9. Sizes range up to 120 cards at about $17.

If you want the "visible" file in a desk-top model, it will set you back about $108 for a 550-card unit, about $195 for a cabinet twice that size.

For the last word in convenience, consider the portable floor model of the "visible" file. During office hours, you can keep it beside your desk for ready reference. Before and after, your Girl Friday can wheel it to her sanctum for updating of the cards, billing, and the like. The file holds more than 1,200 cards in spring-operated, vertical slides. It's fire-resistant, carries a price tag of $325.—NELSON ADAMS

[*See pages 60, 61 for pictures of principal types of filing cabinets.*]

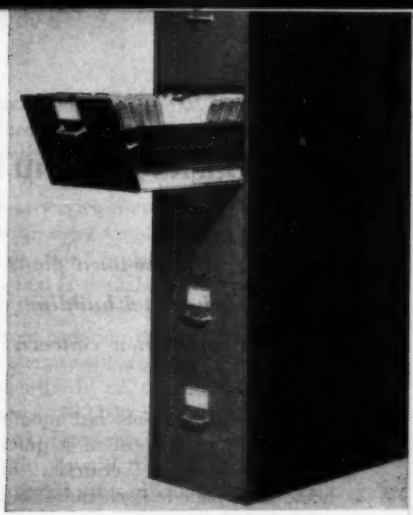
Battery of matched filing cabinets keeps secretary's desk clear.

FIREPROOF cabinet costs $250, keeps records safe behind a steel swinging door. Underwriters Laboratories say contents won't burn or char even when outside temperature hits 1700° Fahrenheit.

ROCK-A-FILE cabinet is handy in close quarters (corridors, alcoves, etc.). It's only a foot deep, takes up 40 per cent less space than conventional unit. Compartments of this model swing out sidewise. Price parallels that of ordinary files.

ODD-SIZE drawers are available in matching, standard-size cabinets. Shallow drawers shown in left cabinet hold small record cards or flat-filed X-rays. Deeper drawers in adjoining cabinet accommodate larger-size cards.

TILT-FRONT "superfiler" helps speed office work. A light pull opens the drawers and drops the front. Then a touch on the index tab clears space around the folder you want. Price is above average.



ALL-IN-ONE "efficiency file" is a multi-purpose unit. Its four record drawers hold 1,000 cards. Letter file has space for a year's correspondence. The safe at the bottom is big enough for a large stack of ledgers. Price is about $60.

ROTARY record holder permits quick location of any patient's card. Metal cabinet can be rolled wherever needed. This model holds 5,500 cards of the 5" x 8" size, has a price tag of $290, takes up relatively small amount of floor space.

V.A. Basks in Calm Between Storms

Criticism of home-town plans wanes, but hospital building program causes new concern

● V.A. medical chiefs last month were making the most of a quiet spell. Once-violent criticism of home-town-plan fee schedules had simmered down to general acceptance by local physicians. An expected barrage against the administration's hospital building program still lay mostly in the future. In the interim, the V.A. had time to take stock of itself.

What it found with respect to the home-town program was mostly good. Relations between the V.A. and private practitioners had improved. A year ago, for example, neither home-town physicians nor V.A. officers were happy about fee-schedule negotiations. A good many medical men thought the V.A. was trying to jam a national schedule down their throats. Today, differences still exist, but most of them are being cleared up through minor adjustments in scheduled fees.

Medicine's fears that the V.A. would short-circuit home-town physicians in favor of staff doctors have proved groundless. Between July 1, 1947 and March 1, 1948, private physicians gave more than 700,000 examinations and 2,099,000 treatments under the home-town program. To pay for all this, Uncle Sam paid out $14,600,000. Although V.A. out-patient departments handled the bulk of examinations (2,700,000), they gave only 1,250,000 treatments.

Last month private practitioners had reason to believe the home-town program would keep rolling. The number of state-wide plans was expected to jump from forty-one to forty-three. (Arizona and Rhode Island were scheduled to start operation this month.)

M.D. Slowdown

Here and there, home-town work may fall off a bit. Until recently, V.A. regional offices could authorize treatment on *prima facie* evidence that a veteran's ailment was service-connected. Now, says the V.A., all non-emergent cases must be formally adjudicated before being okayed for home-town care. In areas where regional offices have been prone to give quick authorizations, some slowdown may result.

The home-town program is not all honey. Touchiest aspect at pres-

ent centers around the handful of doctors who try to beat the system. Chief Medical Director Paul Magnuson warned recently that he intended to root such men out of the program. Up to last month, less than thirty such cases had been reported. Less than half a dozen had been turned over to a district attorney for prosecution.

The V.A. expects some harsh words from medical men because osteopaths now participate in the home-town program. The law requires the V.A. to recognize D.O.'s, but until recently none had received home-town cases. Now, if an eligible veteran requests in writing that he get osteopathic treatment, the V.A. goes along with his request.

While the home-town program glides along on an even keel, the V.A. hospital program seems headed for rough water. The administration is hampered by personnel shortages in many of its institutions. At the same time, complaints are mounting that the V.A. gives free hospitalization to large numbers of veterans who ought not to get it.

A veteran is hospitalized for a non-service-connected condition (1) if he signs a statement that he cannot afford private care, and (2) if a bed is available. That policy was set by Congress. The V.A. cannot even question the authenticity of a veteran's affidavit. As a result, about two-thirds of the administration's usual 100,000-patient census consists of non-service-connected cases.

In view of the V.A. construction program, this situation has caused concern among medical and hospital leaders for some time. The V.A. has 51,911 new beds in various stages of building. Only 830 are expected to be ready this year; another 5,360 in 1949; the remainder in 1950 and 1951. When the program is complete, the V.A. will have about 140,000 permanent beds, equal to about 40 per cent of all the private hospital beds in the country. Will this push the per-

Double Standard

• A young lady in obvious distress came to me for an examination. It turned out that she was pregnant. When told so, she began to weep copiously and to cry out, "What shall I do? What shall I do?" Consolingly, I replied that the simple solution was to marry her fiance. At that, her tears dried and sparks of anger flew from her eyes. "Indeed not!" she snorted. "I'd never marry a man of *that* type."

—M.D., PENNSYLVANIA

centage of non-service-connected cases even higher?

Some laymen and newspapers are beginning to ask that question. A few Congressmen have made motions to look into the situation. But few people think any action will be taken in an election year.

Meanwhile, the V.A. has some additional worries traceable to its expanding network of hospitals. Already some 5,000 beds are closed because of shortages of qualified personnel. And this month the administration will lose up to 1,500 young doctors educated in the wartime ASTP and V-12 programs. On loan to the V.A. from the armed forces, they have ended their two-year hitches and are getting out.

To offset its drying supply of doctors, the V.A. is offering some gilt-edged appointments. Approved residencies in medicine, surgery, and neuropsychiatry are described as a smooth road to certification. Approval arrangements in other specialties are being worked out, too. And the V.A. pays unusual salaries to men seeking certification (from $4,902 to $7,102 a year).

Whether such enticements will bring in enough practitioners to man its hospitals is the V.A.'s biggest question mark. For physicians, the problem remains: Will Congress do anything to change the policy on non-service-connected cases? On both counts the answer is likely to be no.—THEODORE BROOKS

"Haven't you forgotten something, Doctor?"

Legal Cues for Reporting Diseases

Court records show high cost of not observing letter of law in reportable disease cases

• Notifying the local board of health about certain diseases encountered is, for most M.D.'s, routine. But don't let this blind you to the legal hazards of failing to make such reports on time. Not only are the fines stiff—*e.g.*, up to $200 for each offense in Massachusetts—but physicians have lost malpractice suits where the only evidence of negligence was failure to make a required report.

When one midwestern G.P. delivered a baby whose eyes were swollen, he treated them for a week, then arranged for further treatment with a specialist. Despite his precautions, the child's left eye had to be removed. A malpractice suit followed. Though the jury ruled in the doctor's favor, that decision was set aside and a new trial ordered: The physician had failed to make the legally required report of the child's ailment.

In a similar case in Massachusetts, the physician was called to treat an infant's inflamed eyes. Next day he reported the case to his local health officer and the child was immediately hospitalized. Despite these steps, the child lost the sight of both eyes. In the malpractice action that ensued, the jury upheld the physician but the appellate court reversed the decision. The law required an "immediate" report, said the higher court; the physician had delayed twenty-four hours.

Stiff Standards

Or consider the case of the Ohio doctor who assured a patient's neighbor that he could assist in the sickroom without danger. Not until the patient had died and his neighbor had become fatally ill was it discovered that the disease was black smallpox. The neighbor's widow sued the physician and won. What clinched her case was the doctor's failure to notify the authorities—even though he hadn't recognized the disease.

Defamation of character is often an issue in reportable disease inci-

[*Continued on* 120]

**Arnold G. Malkan,* LL.B., *author of this article, is an instructor in business law at the City College of New York and a practicing Manhattan lawyer.*

A Doctor-Operated Convalescent Home

Largely untapped by medical men, this field of activity offers interesting prospects to owner-operators

● When the middle-aged doctor wants a change of pace, what can he do about it? How can he escape the daily grind of medical practice without suffering a marked drop in income? One answer that's often overlooked is the management of a small convalescent home.

Says Dr. Harry Gomberg, who owns and manages one of forty beds in Chicago: "A convalescent home —particularly one specializing in the care of the chronically ill—can be a profitable, satisfying venture for the doctor who wants to try a new field. It's not a get-rich-quick proposition; but, if built up gradually and managed carefully, it will start to bring in a substantial income within a few years."

The physician opening a convalescent home today will find little competition. In one of the most complete inventories of U.S. convalescent care facilities published in recent years, the New York Academy of Medicine listed just 164 convalescent homes for adults and children, with a total capacity of 12,219 beds. Hundreds of small convalescent homes were left off this list, but most of these have only ten beds or less and only limited provisions for medical care.

Few private convalescent homes (except those admitting mental cases and alcoholics) are operated by medical men. Usually a nurse is in charge. Yet from the patient's point of view, the advantage of doctor-supervision is obvious. Says a spokesman for one midwestern welfare group: "Good private convalescent homes are few and far between. The entry of more doctors into this field would certainly help to raise the standards."

Full House

A study of the operation of Doctor Gomberg's institution shows the possibilities. With forty beds, the home is presently filled to capacity. The doctor estimates he could fill another ten to twenty beds if he had more space.

The home is located in a trim, forty-five room building designed originally for three families in the upper-income bracket. The first and second floors are used for patients, the third floor for nurses' quarters and the Gomberg apartment. Of the twenty-three bedrooms used for

RESIDENT PHYSICIAN in this successful convalescent home is its owner-manager, Dr. Harry Gomberg.

patients, eleven are single rooms; the others hold from two to six beds apiece. Also provided for the use of patients are two sitting rooms and two large, screened-in porches. On summer days, the patients may also lounge in an adjoining park.

A convalescent home, Doctor Gomberg maintains, should realize a profit for its owners of about 40 per cent of gross income. The gross income of his own establishment last year totaled about $57,000. Total expenses (not including any payment for Dr. and Mrs. Gomberg's services) were about $37,000, leaving a balance of approximately $20,000.

Of the $37,000 total expenses, slightly more than one-third was spent for food. Another one-third went for wages. The remainder was ticketed for such items as real estate taxes, coal, gas, electricity, insurance, maintenance, and miscellaneous overhead.

Convalescents at the home pay from $30 to $45 weekly. The rates used to be much lower but have been raised as costs of labor and overhead went up. Five years ago, for example, the rates were about $20 to $25 a week.

Doctor Gomberg's staff includes two registered nurses, two practical nurses, two trained nurses, two cooks, two cleaning women, and two handymen. The nurses receive an average of $85 a month, with room and board. Other employes are paid from $21 to $38 a week, with meals.

Doctor Gomberg established his first convalescent home in 1932, after fifteen years of private practice in Chicago. His regular patients, suffering from depressionitis, were showing a marked inability to pay

their bills. So the enterprising M.D. began looking for some source of regular income. He hit on the scheme of renting a small apartment building (for $60 a month) where he and his wife could live and take care of a few convalescents.

By the end of the year, the home had four convalescents and the services of one nurse. The doctor was encouraged to switch to a larger building with room for eighteen beds. As the experiment gathered momentum, Doctor Gomberg gradually dropped most of his regular practice and devoted more time to the care of convalescents. He bought his present building in 1941 at a cost of $15,000. It took another $3,000 to equip the place for forty convalescents.

Today most of the home's tenants are more than 70 years old. Eight of them are diabetics, four are rheumatics, four are cerebral hemorrhage cases. The remainder have cardiac conditions or miscellaneous infirmities of old age. Only ambulatory patients are admitted, but if these become bedridden while in the home, they are permitted to remain.

"Decide what type of convalescents you will admit, then stick to your decision," Doctor Gomberg recommends to doctors who contemplate following his lead. "Otherwise you may invite trouble that

[*Continued on* 114]

"I faid I'm just a bruff falesman who dropped in to fee if you needed anyfing!"

The Facts About Term Insurance

Dollar for dollar, it's the least expensive way to assure protection for your family

• It's the most misunderstood kind of life insurance listed in the agent's rate book. Yet it's the oldest type of life protection known—dating back to the early eighteenth century, when British ship-owners insured their skippers for the "term" of the voyage.

It's sometimes spoken of as "die-to-win" protection. Yet term insurance is as good basic protection as your money will buy—if you use judgment in buying it. Here's why:

Stripped down to essentials, the purpose of life insurance is to replace the economic value of your life to your dependents. The only type policy that does that *and nothing more* is term insurance. Because of this, it offers the least expensive means of protecting your dependents in the event of your death.

For a physician of 35, the cost per thousand dollars of term insurance ranges between $10 and $20 a year, depending on the length of the term. This premium rate may run as low as half that of ordinary life insurance, one-third that of twenty-payment life, and one-fifth that of a twenty-year endowment policy.

To many people, term insurance is suspect because it is so cheap. But as insurance rate-making becomes better understood, the term contract is beginning to take its rightful place in most insurance programs. Consider, for a moment, how premiums are set:

Computing Your Bill

Three cost factors go into insurance rate-making: (a) mortality cost; (b) administrative cost; and (c) a "loading" for cash and loan values and perhaps for dividends. The first two items remain fixed and inescapable; they vary but little from company to company. The variation comes in item (c), which can range from nothing to a good share of the premium dollar. That's what runs up life insurance costs.

Under any form of life insurance *except* a term policy, item (c) makes up part of the premium cost. You are then combining savings

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**W. Clifford Klenk, author of this article, is a well-known New York insurance analyst and consultant.*

The Doctor Looks In the Mirror

● To write an autobiography, you don't need a medical diploma—it just seems so.

An autobiography is the result of someone's conviction that he has led a singularly interesting life. This intimation beats within the breast of all mortals. For proof, hear a woman describe buying a hat, or a man tell how the front fender of his car was bashed in, or a patient unfold the saga of his operation.

The chief requirement for writing your life's story is either a prodigious memory or the foresight to jot down your *bon mots* and heroic deeds as they occur. Since the public may not accept you in the form of a twenty-volume encyclopedia, the first problem will be to weed through your trunkful of notes and arrange them in logical order. A suggested outline would include the following categories:

Childhood—The Annunciation: Thus in the midst of a full and happy childhood it came to you, as you watched your fa- [*Continued on* 97]

with life insurance. You are allowed to borrow on your policy, but when you do, you always reduce your insurance by the amount of the loan—and, in addition, pay 5 to 6 per cent loan interest.

Suppose, on the other hand, you take out term insurance. Suppose you put the difference between the term premiums and those of any other type of life insurance into a savings bank. You'll then be able to borrow from this fund without charging yourself interest—and without reducing your insurance protection.

Cash-in value is often touted as an advantage of the higher-premium types of insurance. But suppose you cash in a 10-year-old, twenty-payment, $10,000 ordinary life contract. You get about $2,300—but you forfeit $10,000 payable in *futuro* to your dependents.

It's Not Loaded

Term insurance generally has no cash values because the premium has no loading for them. There is nothing illogical about such a plan, except in the hands of someone with an axe to grind for insurance contracts that yield a substantially higher sales commission.

Term contracts are usually written for from one to forty years. All carry the right to convert to a higher-premium form of life insurance. Many carry renewal privileges (which for best protection, you should insist on).

To show how term insurance works in a specific case, consider the family of Doctor Blank. He's 35, his wife is 30, and their two children are 1 and 2. Doctor Blank feels that if he died next month, he'd want his family to have an income of $250 a month until the children were in their early twenties. To provide for this would take $47,400. In other words, he needs $47,400 worth of life insurance.

If he bought an ordinary life policy in that amount, the premium would come to $1,000 a year. Instead, he buys a twenty-year term policy with premium of only $525 a year. What's more, he can reduce the total amount of his insurance each year, as his children draw closer to the age of self-sufficiency. Thus, after five years, he will have lowered his total amount of insurance by perhaps $9,000—and premiums will be down to $429 a year.

What are the drawbacks of term insurance? Mainly that you have to shop around to find what you want. Not all forms of it are offered by all companies. Then too, older physicians have only a limited choice of term policies, or perhaps none at all. But for those who are eligible and who can take time to investigate, term insurance is an attractive means of gearing family protection to family needs.

—W. CLIFFORD KLENK

"He just *loves* to play doctor!"

The Paradox of Stock Prices

Unnaturally low price-earnings ratios have puzzled investors and market analysts alike

● Generations of doctor-investors have used the price-earnings ratios of common stocks as a guide to their value. If the market price of a share was less than ten times its annual earnings, the stock was generally considered a good buy. But in the past year, this time-tested yardstick seems to have gone to pot.

Many a physician who in recent months glanced at the Wall Street fever charts in the financial section of his newspaper had reason to scratch his head. Until their mid-May upsurge, stock prices had ambled downhill since 1946. Stock earnings in the same period had veered steadily upward. Tentative diagnosis: "an interesting case."

By all the old standards, stocks had been selling at clearance-sale prices. At the end of this year's first quarter, industrials were going at an average of nine and one-half times earnings. Such traditional blue chips as General Motors, Westinghouse, Standard Oil of New Jersey, and Sears, Roebuck were selling at price-earnings ratios of between eight and nine. U.S. Steel was selling at about six times earnings; Goodyear Tire, at only four times earnings. Yet despite such bargain-basement price tags, investors weren't buying.

The average stockholder wanted to know, "What's up?" But he wasn't getting much help from the published opinions of the market analysts. Some blamed the phenomenon on "defeatist psychology born of long conditioning" or "lack of faith in capitalism." Others, looking for a dollars-and-cents answer, said flatly that investors didn't have the money. Sure, they admitted, there was loads of cash in circulation; but record cost-of-living prices were snagging most of it.

Tax Damper

Fortune Magazine suggested another reason: The hundred-thousand-plus people with incomes of over $25,000 were "depressed by heavy taxation." According to Fortune's analysis, these mainstays of the stock market had an aggregate of $7.3 billion after taxes in 1929. By 1943, surtaxes had cut that amount by $4.7 billion and had put a heavy damper on investment incentive.

Toward the middle of May, the

market situation began to change. The new Federal income tax law had gone through; common-stock investments began to look more attractive because Uncle Sam could then take less of a cut out of income from them. At the same time, with war industries due for a renaissance and with foreign aid gathering momentum, U.S. business began to boom. All this was being reflected on the Wall Street ticker.

Profits Zoom

Analysts noted that business profits, dividend payments, and common-stock prices had, in the past, borne a relatively stable relationship to each other. But since prewar days, corporation profits had grown five times as large; total dividend payments had doubled; yet stock prices had risen only about one-third. A bull market seemed sure to come.

What might keep the late-spring flurry in stock trading from turning into a full-fledged bull market? For one thing, there was the possibility that taxes on corporation income might be boosted if rearmament and Marshall Plan costs upset the Federal budget. On the other hand, if spending for war materiel or for foreign aid turned out to be less than expected, a number of corporations might feel the pinch. In either case, stock prices would probably level off.

But most market analysts took a brighter view of things, predicted a boom lasting into 1949. If they were right, the doctor-stockholder could expect an early end to paradoxical price-earnings ratios. But for the moment, all he could do was peer wistfully at market reports and hope that inflation had finally hit the only place it had missed so far.

—J. D. OBERRENDER

Pay as You Go

● While practicing in the Ozarks, I was called out late one night on a confinement case. I drove toward the isolated farmhouse, only to find it located on the other side of a narrow, bridgeless river. My yells brought the husband out and he ferried me across. After delivering the child, I told the husband my fee was $25. He countered: "I'm charging ye $5 for bringing ye across the river and $5 for bringing ye back. Here's the $15 I owe ye." When I objected to being charged for the boat trips, he retorted: "Ye don't figure I'm going to paddle around in cold water at this time of night for nuthin', do ye?"

—M.D., OREGON

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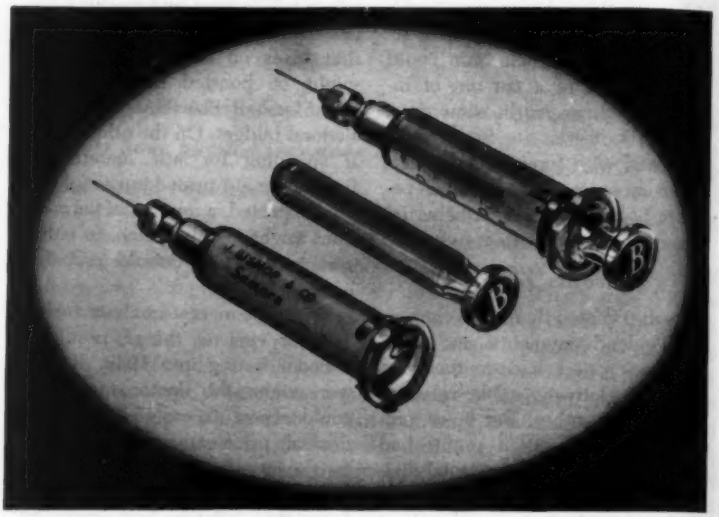

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Union and Co-op Plans Seek AMA Nod

Consumer groups and AMA air differences on how to control quality of prepaid medicine

• AMA officers last month were slated to start two important series of talks. The first was to be with representatives of medical co-ops, the second, with labor union officials. Topping the agenda of both conferences was the explosive question of AMA approval standards for prepay medical care plans.

The outcome would mean either (a) organized medicine's blessing upon doctors taking part in co-op and union medical plans, or (b) its implied warning that such plans were still unsanctioned and therefore to be avoided.

The issue has long been a thorny one. The AMA has been studying co-ops for almost two years with an eye to setting up proper standards of approval. For various reasons, including the reluctance of some co-ops to disclose details of their operation, the study has remained incomplete. Meantime, co-op leaders have accused the association of stalling.

At the National Health Assembly held in Washington in May, the divergent factions approached this matter with some truculence. But before the NHA was over, the AMA set the stage for the subsequent series of conferences. What's more, general agreement was reached on these preliminary points:

1. "Full control of the practice of medicine must remain with doctors."

2. "Voluntary prepayment embodying group practice and providing comprehensive service offers the best available means, at this time, of bringing about improved distribution of medical care."

3. A prepay plan should be judged partly by the extent to which its governing board "represents the interests of those entitled to service as well as of the physicians, hospitals, and others providing the service."

HIP Snubbed

The temperate atmosphere of the NHA did not spread to all parts of the country. In mid-May, New York state society medical delegates advised their 22,000 fellow-members to participate only in the six society-approved prepay plans in that state. Thus they turned a cold shoulder to the controversial Health Insurance Plan of Greater New

York, as well as to co-op and labor union plans. The society stated flatly that unapproved plans resulted in "the patient's receiving poorer medical care."

All of which will scarcely still the clamor being raised by some co-op spokesmen. Says an officer of the Farmers Union: "For four years we have been trying to develop a co-op clinic for 1,000 families in Williston, N.D. We've got money, space, and equipment. We've asked the cooperation of the medical societies, but we simply can't get a doctor. Some doctors have signed with us and then changed their minds." Unfair pressure from organized medicine is to blame, the union charges.

Monopolistic?

Another hot question is broached by Horace R. Hansen, general counsel of the Cooperative Health Federation of America: "The AMA says it favors the voluntary approach. Why, then, do the AMA and the state associations seek monopolistic legislation which prevents any consumer-sponsored plan from getting started?"

Part of the answer comes from Jay C. Ketchum, executive vice president of Michigan Medical Service: "The Michigan act looks monopolistic but isn't. It's possible to organize a co-op in this state simply by posting sufficient cash with the Commissioner of Insurance."

Progressive Midwest

Other medical spokesmen point out that some state societies are taking active parts in campaigns to modify co-op enabling laws. Wisconsin's medical society, for example, helped draft new legislation for cooperatives in that state. Minnesota physicians have shown themselves willing to assist in a similar project aiding the health cooperatives.

Union prepay plans, many of them new arrivals on the medical care scene, have roused no such controversy as yet. Nor has the pattern of union medical plans become so clear.

But union leaders frequently criticize Blue Cross and Blue Shield. They appear to favor clinics staffed by salaried physicians who are paid from welfare funds.

What union moguls will probably want from the AMA is a loose set of standards that can be applied to a wide variety of prepay medical care plans in all states.

—HENRY O. PETRY

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**Reich, Button and Nechtow, "Treatment of Trichomonas Vaginalis Vaginitis," Surgery, Gynecology and Obstetrics, May 1947, pp. 891-896*

What Rehabilitation Offers the M.D.

One of the newest fields for medical men provides plenty of opportunity for G.P.'s

• A million and a half American civilians today need medical and vocational rehabilitation. Here is a vast pool of patients scarcely tapped by the medical profession, a potential source of gratifying and remunerative work for doctors interested in getting patients from wheelchair to workbench.

While many of these patients are "medically indigent," few of them need be free cases: Every state in the union has a rehabilitation program that includes the purchase of medical services. With substantial aid from a Federal kitty, each state operates its own program, sets professional standards, and pays physicians according to an established fee schedule.

The family doctor is figured to be the key practitioner in the program. He is needed for the basic medical evaluation on which each patient's rehabilitation schedule is constructed. What's more, many of the project's procedures and treatments can be carried on by G.P.'s.

Surprisingly few physicians are aware of this program. A recent report shows that only 3 per cent of state-Federal program beneficiaries were referred by their physicians. The Federal Security Agency has issued a booklet that highlights the role of the general practitioner (it's called "The Doctor and Vocational Rehabilitation"). But few physicians know of this book or have written to request copies.

Which may help explain the gap between direct medical or surgical treatment and restoring the disabled patient to economic usefulness. Such patients have to be retrained. Previously, this training was considered the function of educators, psychologists, and lay counselors. But if rehabilitation is thought of as a phase of medical care, then, like the other two phases (prevention and treatment), it becomes a job for M.D.'s.

New Role for Doctors

The medical practitioner cannot, of course, conduct vocational training classes, administer aptitude tests, or operate a job placement bureau. But he can define the area in which the rehabilitant can operate. He can set the limits of his work tolerance, put him in touch with appropriate agencies, main-

tain professional supervision over the man's program. Basic to any person's plan for vocational rehabilitation is its medical feasibility. That's one reason the doctor can be the key man.

Hospitals Awakening

Hospitals are beginning to recognize that the management of convalescence and the fitting of the patient to his job are parts of their responsibility. New York's Bellevue Hospital has led the way with an active rehabilitation department under Dr. Howard A. Rusk, the country's top rehabilitation physician; but Doctor Rusk estimates that 150 other communities are showing enough interest to make it likely that many comparable projects will soon be established. Some projects will be in community hospitals. Others (like New York University's new rehabilitation institute) will be linked to medical schools.

Rehabilitation means shaping the patient so that he can return to gainful employment. Not to selling pencils, either, but to a job that suits his education, intelligence, aptitudes, and interests. Sometimes this can be done by schooling, sometimes by physical retraining.

If the disability consists of stuttering, rehabilitation implies speech correction. In other cases, it may mean learning Braille, studying watch-making, participating in group psychotherapy, taking an apprenticeship, or learning to read lips. It may begin with teaching a

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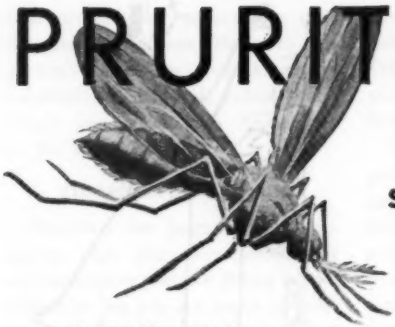

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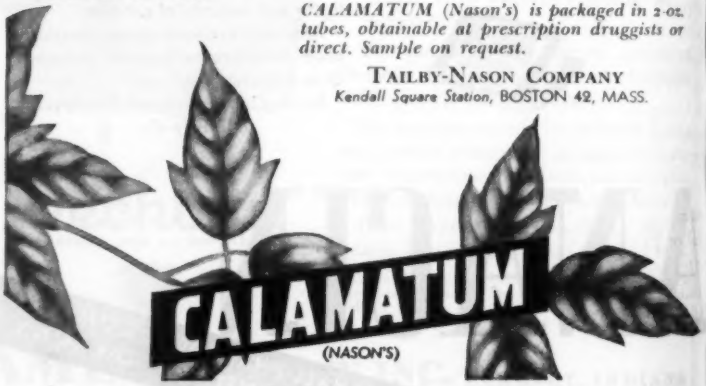

lips. It may begin with teaching a man how to slide from a bed to a wheelchair or how to articulate sounds after the larynx has been removed. Even in the simplest case, it involves a plan for a whole person, not just a plan for training one set of muscles.

For this reason, the G.P. is the logical man to integrate the program. Rehabilitation never lies entirely within one medical or surgical specialty. A complete project may need the services of teachers and physical therapists, social workers and speech correctionists, nurses and occupational therapists, vocational counselors and psychologists. For almost every patient, a good-sized team is required. It's the doctor's privilege to be quarterback.

Is He Eligible?

Some 200,000 civilians each year enter the army of the disabled. To do his share for such patients, the doctor first contacts the division of vocational rehabilitation in his state capital (or he gets a local address from the Office of Vocational Rehabilitation, Federal Security Agency, Washington 25, D.C.). He sees if his patient is eligible to participate in the government program. The five eligibility requirements are (1) that the patient be of working age; (2) that he have some physical or mental condition that constitutes an employment handicap; (3) that this condition be static or only slowly progressive; (4) that the disability be reducible by training or treatment; and (5) that the patient be financially unable to pay the full cost of the treatment or training program.

The doctor then refers the patient to the state rehabilitation agency with the request that he be designated the examining and treating physician. He will have to meet the professional requirements set up by the state, but these are usually reasonable. In most states, any reputable physician is eligible to participate to the limit of his skills.

The government pays for the medical services if the patient cannot afford them. Within fair limits, it also meets necessary hospital bills and costs of vocational guidance, prosthetic appliances, and job-finding. If the patient can pay part of the costs, he is expected to do so.

[*Continued on* 84]

* HANDITIP *

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A short piece of rubber tubing is a big help when replacing those tiny electric bulbs in the hard-to-reach sockets of otoscopes, ophthalmoscopes, cystoscopes, and the like. I push the glass end of the bulb into the tubing, then use the tubing as a handle for screwing the bulb into the socket. —M.D., NEW YORK

* * * * *

Actually, the government gets its money back via the rehabilitant's increased earning capacity and consequent income-tax payments. During 1945, it cost the Federal Government some $7 million to rehabilitate the people on its rolls. During their first working year after rehabilitation, these same persons

paid back some $6 million in Federal income taxes. By the following year, Uncle Sam had been more than reimbursed for the program's cost.

The physician who wants to learn more about rehabilitation will find the literature scanty but growing. Most prolific writer in the field is Doctor Rusk. Any interested physician can obtain pamphlets and reprints by writing him at Bellevue. Most recent book on the subject is Henry Kessler's "Rehabilitation of the Handicapped" (Columbia University Press, Morningside Heights, New York 27, N.Y.). More specialized aspects of the problem are presented in Charles Curran's "Personality Factors in Counselling" (Gruene and Stratton, 381 Fourth Ave., New York 16, N.Y.) and in F. H Everhardt's "Therapeutic Exercise" (Lea & Febiger, Washington Square, Philadelphia 6, Pa.).

One other bit of knowledge the physician needs is familiarity with the social and vocational resources of his community. He should have available a list of vocational guidance experts, social agencies, speech correctionists, employment bureaus, Braille teachers, sources of prosthetic appliances, physical therapy technicians, teachers of lip reading, occupational therapists, and the like. The state rehabilitation agency will give him a start on assembling such a list.

Thus equipped, the doctor can launch a career or sideline in one of the newest, most rapidly expanding, and most hopeful aspects of practice: human rehabilitation.

—WILLIAM MACDONALD, M.D.

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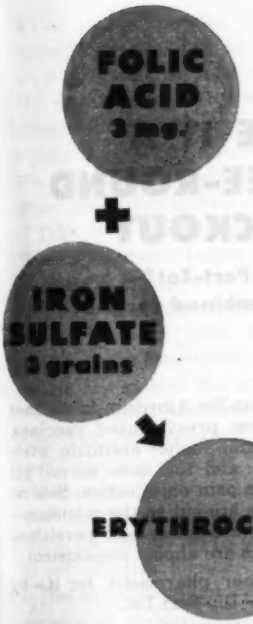

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Socialist Tag on Wagner Bill Just Propaganda, Says Murray

Cites history of attacks on other Federal acts, decides his bill is in good company

• One of the common arguments against a national health insurance act is its alleged socialist character. My reading of American history persuades me that there is hardly a piece of progressive social legislation that wasn't at one time or another attacked on the same grounds.

Take workmen's compensation: When the states began to adopt workmen's compensation legislation, the opposition proclaimed that private property and individual liberty were threatened, that socialism lay around the corner.

The National Association of Manufacturers was opposed to workmen's compensation. It fought deviously—always proposing a "voluntary" mechanism as a last resort when the people were determined to get effective legislative action.

Just as today voluntary health insurance is suddenly espoused by the opponents of national health insurance, the NAM, back in 1910, advocated voluntary workmen's compensation. As one spokesman put it then: "This country is not keen for government by paternalism. Unless the whole working of compensation shall ultimately rest in a new and extended bureaucracy, that problem must be worked out by mutual associations of employes, encouraged by employers."

Tax-supported public education is another example. Today it is regarded as the birthright of every American. But a hundred years ago, opponents of free education called it "infidel socialism in its principles, unjust and oppressive in its operation, immoral in its tendency, irreligious in its consequences, and injurious to the cause of education."

And when Congress in 1894 debated a tax on income, many assailed the levy as socialistic and un-American. "It is an insidious and communistic leveler," said Representative Baker of New Hampshire.

[*Continued on* 105]

**Here, condensed, is a statement presented by Sen. James E. Murray (D., Mont.) at hearings held this year on the Taft and Wagner health bills.*

Tales From a Placement Bureau File

The physician who job-hunts often discovers that the field is full of surprises

• When the doctor goes job-hunting, anything can happen. He may wind up in a chess match, on a safari, or even spliced. The medical placement agents handle such an assortment of strange cases that they're seldom surprised any more. But to the average M.D., the bureaus' bill of fare sometimes seems wild and wonderful.

Consider, for example, these oddities culled from the records of several leading placement agencies:

A middle-aged surgeon, a bachelor, was looking for a spot as a physician in a construction camp. He wanted to go deep into the jungle, where he could study exotic birds on the side. The placement agent was young and rather exotic herself. Six weeks later, the doctor found himself ensconced in the wilds of suburban Chicago with a wife and a canary.

Or consider the young doctor who asked for "some place cool." He was soon on his way to a job in Reykjavik, Iceland—which happened to be his home town. Then there was the physician whose warbride had a yen to go back to Australia. A placement bureau promptly installed him as ship's physician on a liner bound for Melbourne.

A job popular with young doctors who can't decide where to settle is that of the physician who travels back and forth from coast to coast in his own private railway car. At each rail center or large repair shop, the car is sidetracked while the M.D. gives routine physicals to railroad workers. Between stop-offs, the doctor has plenty of leisure to inspect the towns and decide where he'd like to set up practice.

Swamps and Circuses

Placement bureaus find that doctors' job requests fall into some interesting patterns. Surgeons, they say, like rough construction camps; tropical medicine men obviously prefer swamp country; M.D.'s with an itch to roam often seek to join up as circus physicians.

Sometimes a job can hinge on the darndest, out-of-the-way qualifications. An M.D. with asthma was snapped up by a supply house that wanted him to test and evaluate new equipment for asthma victims. In another case, ability to play chess

[*Continued on* 106]

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It contains half as much sulfur as the standard Full Strength Intraderm Sulfur Solution. Supplied in the same Intraderm Skin Penetrant Vehicle.

Half Strength Intraderm Sulfur has been clinically tested on numerous cases with gratifying results. Many physicians consider that it contains as much sulfur as is needed for an average case.

Intraderm Sulfur is a true solution. Neither the Full nor the Half Strength can be diluted without precipitating the ingredients.

Clinical samples sent on request to physicians in U.S.A. only.

On Rx at Drug Stores.

Greater Flexibility in Treatment

Half Strength Intraderm Sulfur is applied in the same manner as the Full Strength. Adjustments are easily made in the frequency of use and the amount applied, according to the individual patient's requirements.

WALLACE DERMATOLOGICALS

Wallace Laboratories, Inc., Princeton, N. J.

Program [*Continued from* 43]

doctor instead of a business man?" the recipient was asked.) A paper on "Recent Advances in Surgery" was described as the entree of a "real meat-and-potatoes program." A talk on office procedures was announced with the dry comment, "It will cost you money to miss this one."

Actual organization of the program required painstaking attention to detail. To make this possible, Doctor Rardin assembled a 100 per cent working committee. There were no honorary or ornamental members. Dr. Rollo Bonnell and Dr. George T. Harding, for instance, handled the social aspects of the program—meeting speakers at the train or airport, arranging hotel reservations, planning informal get-togethers before and after the meetings. Dr. Clark P. Pritchett and Dr. Robert H. Schoene took care of such publicity devices as bulletin items, newspaper notices, biographic material, postcard reminders, and promotional letters. Dr. Emmerich von Haam was responsibe for liaison with the local medical school and for the attendance of medical students. Dr. Ralph Marsicano edited the advance notes furnished by the speakers, supervised their distribution to members, and handled the mechanical arrangements of the meetings (including lights, projection apparatus, pointers, blackboards, call board, and other accessories). Thus, every member of the committee had a job to do; and for every detail of the program, some committee member assumed responsibility. The committee's ideas received warm backing from Academy President Charles W. Pavey and his fellow officers.

Mimeographed notes prepared in advance by each speaker proved a highly successful innovation. They set forth essential facts the speaker wanted his audience to have for future reference, and were distributed at the end of each talk. Only one lecturer balked at preparing advance notes; then, after he saw samples of those furnished by his predecessors, he felt inspired to measure up by preparing a useful set of his own.

Talks were given twice a month, October to June. While the entire kaleidoscope of medicine and surgery was covered, all lectures were focused four-square on the G.P. Summarized in the accompany-

Significant Clinical Results in Certain Allergic Disorders

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★ **Patients who fail to respond satisfactorily to other therapeutic methods may receive effective symptomatic relief from *Neo-Antergan*.**

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INDICATIONS: HAY FEVER • PRURITUS • URTICARIA • VASOMOTOR RHINITIS • ATOPIC DERMATITIS ECZEMA • ALLERGIC DRUG REACTIONS • and certain other allergic disorders.

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ing box is the 1947 all-star program.

Each speaker was paid a $50 honorarium and reimbursed for travel and hotel expenses. An additional allowance was made for the expenses of his wife if the lecturer brought her along. The entire project cost the academy a little over $1,200 for the fourteen meetings.

Arrangements were made to meet each speaker on his arrival in Columbus. If he wanted to visit friends in the city, the committee fitted this into his schedule. He was entertained at luncheon or dinner. A member of the auxiliary was assigned to escort the speaker's wife, to acquaint her with Columbus, to give her tips on shopping, and to make her stay a pleasant one.

At each meeting, the off-platform staff included four physicians to pass out the mimeographed notes, a projection machine operator, two clerks to answer the telephone, an usher to post names on the call board, a kitchen maid to help prepare the collation, and a half-dozen auxiliary members to act as hostesses.

The season's program was acclaimed the best ever presented. It got nationwide attention, boomed academy membership, and attracted the greatest attendance in the academy's history.

Out of his experience with this project, Doctor Rardin has distilled a good many pointers for program chairmen. Some samples: Start the meeting off with the main talk, not with a dreary reading of minutes or committee reports. Give thought to the gracious entertainment of the speaker. Avoid a lecturer whose interest is concentrated in one narrow topic. Avoid, too, those who have troublesome accents or an overpedantic style of delivery.

Select topics that touch on new

Busy Body

• The young woman who entered the pediatric clinic with a small baby complained that the child was taking his breast feeding poorly. Our professor thought the case of sufficient interest to call in the entire section. He asked the young woman to undress so that each of us—eight in all—could palpate her breasts, noting how underdeveloped and nodular they were. After we had finished, he explained to her the course she must follow to improve lactation. Only then did she volunteer the information that the child was not her's, but her sister's.

—M.D., NEW JERSEY

ideas, the classification of obscure points, and the integration of the physician into cultural and civic life. Don't overlook meaty pointers on diagnosis or treatment. Get out-of-town authorities whenever possible since they are always better drawing cards than equally well qualified home-towners. Have an outstanding local doctor open the discussion when the speaker is from another city. Make full use of teaching aids like moving pictures, charts, phonograph records, displays, models, and lantern slides. Be sure the hall is equipped to permit optimum use of these accessories. Emphasize the after-meeting social period.

Publicize each meeting through every channel available, including community newspapers and word of mouth. In preparing advance announcements, boil down the wording to the dramatic high-points of the subject. Entrust the entire operation of the program—from selecting speakers to scheduling social events—to a small committee with specific allocation of responsibility among its members.

Any compact committee willing to do sleeves-up work on the project, headed by a chairman with some organizational or teaching experience, should be able to carry through a program like the Columbus academy's thumping success. Medical societies that follow this lead are likely to wind up with a gratifying sense of "mission accomplished."

—EDWARD E. RYAN

Television in Waiting Rooms

Giving patients something to watch while they wait builds reception room morale

• The doctor pokes his head into the reception room. "You can come in now," he says to a man who has been waiting two hours. The patient glances up, frowning at the interruption: "Not so fast. Can't you see I'm busy?"

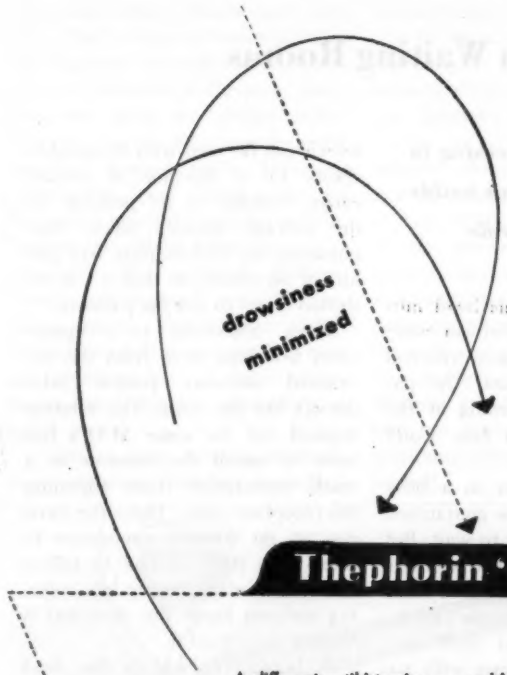
A television receiver in a busy reception room can't be guaranteed to make patients *want* to wait. But M.D.'s who have installed sets feel that the return in good will more than justifies the purchase and installation price (about $400 up). "In an office overflowing with patients," says one, "a certain amount of waiting is inevitable. But with television, I've succeeded in brightening up the glum faces that used to greet me whenever I opened the reception-room door."

Mothers especially are grateful for the job television does in keeping children quiet and amused. Televised children's programs have proved more effective for waiting small-fry than the customary lollipops, hobby horses, and comics.

Since the conventional-sized screen can be seen with reasonable clarity for a distance of several yards, visibility is no problem in the average doctor's office. One physician in Philadelphia has put his set on wheels so that it can be shifted about to suit his patients.

Minor objections to reception room television stem from the occasional nervous patient who doesn't like the noise. The solution worked out by some M.D.'s has been to install the receiver in a small, soundproof room adjoining the reception room. There the show can go on without annoyance to those who don't choose to follow it. The secretary simply lets entering patients know the diversion is there if they want it.

A bigger obstacle is the short range of transmitting stations, which limits reception to areas close to large metropolitan centers. Even in these regions, video fans report a scarcity of morning programs. That means waiting-room television is more practical for doctors who have late afternoon or evening office hours. Also, since a large percentage of programs feature sports or children's attractions, television has more appeal for the very young and for male patients than it does for women. —ROBERT M. HARLOW



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T. M.—Thephorin—Brand of phenindamine. Chemically, Thephorin is 2-methyl-9-phenyl-2, 3, 4, 9-tetrahydro-1-pyridindene hydrogen tartrate.

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The Mirror [*Cont. from* 70]

ther castrate his cattle, or your sister have a nose bleed, or your neighbors succumb to Tsutsugamushi fever, that you would become a Doctor.

Early Youth — The Resolve or Dedication: What with going to school and working on your newspaper route, it was not easy to perfect yourself in the basic arts and techniques that were to prove so valuable later. (You comment here on your first motor-driven amputation saw, on the effects of anoxia on earthworms, on feeding your dog onion soup.)

Medical School—Professional Aspect: You describe the great characters and teachers you studied under and the inspiration they gave you. (You got an A in everything but neuroanatomy. The professor gave only B's in this course because no one knew where the soul was.)

Medical School — Social Aspect: In this section you want to prove that you were not a prig and that all work and no play and so forth. So you recount the gayer aspects of your student life (how you spent the weekend in jail after drinking the ether from the operating room; how you cached the anatomical specimen in your landlady's handkerchief; how you met the woman who was destined to become your life partner).

Interneship—Historical: Now you are warming up to the heart of your book. You enter the subject obliquely. First, you note the quaint aspects of the physical facilities (the horse-drawn ambulance, the operation in dress suit). Then you tell about the personnel (those old duffers were actually better doctors, although they knew nothing about blood counts and such). Next you come to your first case, which you have never forgotten to this day. (At this point you may become somewhat suspicious of yourself, noting that your memory for the long ago is much better than for recent events.)

From here, your medical memoirs will depend on your literary methodology. You may remain

Voice of Experience

• My wife, who is also the mother of my six children, ordinarily answers the telephone for me. Recently a woman called up and asked if I were a doctor of medicine. After my wife had assured her I was, the woman inquired hesitantly, "Does the doctor practice that there birth control?" Said my wife, who is never at a loss for words, "Not to my knowledge." —M.D., OHIO

chronologic, detailing each change of residence. Or you may write your chapters according to topics and themes. At any rate, you're pretty sure to cover some such subjects as these:

The Spice–Humor and the Bizarre: The patient who swallowed his toupee, etc.

The Dramatic: Performing an appendectomy on the carrousel during the county fair.

The Firsts: The number of these will depend, of course, on how great an innovator you were. You should be good for some firsts, even if only first-to-suggest-washing-milk-bottles-in-your-county. The idea is to make your life sound like pioneer stuff. Quote the death rate before you started practice and twenty years after.

The Philosophical: At this point, you improvise, and no factual ban need hinder you. Some suggested jumping-off points:

(a) "Medicine Yesterday, Today and Tomorrow." Under this heading you discuss such questions as "Does penicillin really change human nature?" or "Is medicine practiced any better today than in days of yore?"

(b) "The Mad Pace." Here you may talk about the effect of internal combustion machines on the incidence of gallstones.

(c) "Miscellany." This heading gives you a chance to try your own private explanation of Hitler's psychosis, or the relationship between smoking and the divorce rate.

Conclusion–Whither Are We Go-

ing: The note here is mellow. You believe you have led a full life and as you gaze on the grandchildren of girls you delivered you are happy. But oh, if you were only 16 again, and able to live through the wonderful discoveries that are bound to come! At this point you give that final proof of your absolute modernity—how you took up flying and marijuana at the age of 78.

There it is: the doctor's digest reduced to its most transparent formula. Yet I'm a sucker for it. When the chips are down and the stethoscope checked in, you can write your epic of "One Doctor's Life" with at least one certainty—I'll buy it. —THEODORE KAMHOLTZ, M.D.

Just Published

ARTICLES

EUTHANASIA—RIGHT OR WRONG? By Selwyn James. The case for legalizing mercy killing. Survey Graphic, May.

MEDICAL KICKBACKS CAN BE ENDED. By Albert Q. Maisel. Tells how the Los Angeles Better Business Bureau stopped local rebating practices; hands out a few slaps at the medical profession for dilatory housecleaning. Reader's Digest, May.

IF YOUR CHILD STUTTERS. What parents can do to help the child who stutters. 6 pp. National Ho-

[*Continued on* 118]

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What Price Medical Society Dues?

Locale, operating costs play major part in fixing price tag on association membership

• Medical society dues fluctuate as sharply from state to state and from county to county as a heart patient's cardiogram. For the privileges and benefits of association membership, the American physician may pay anywhere from $10 to $100 a year. State dues range from $10 to $60, average about $27. County dues range from nothing to $65, hit a mean of approximately $15.

These figures stem from a study conducted recently by MEDICAL ECONOMICS. To assemble data on dues, medical societies in every state were contacted. The 246 questionnaires that were returned form the basis for this sampling.

The study showed that dues tend to be higher on the West Coast and in the Northwest. They tend to be lower in the South, the Middle West, and East. Basis for such differences is partly regional and partly precedent. It is influenced also by practical considerations.

Operating costs and financial strength of the individual society figure high in dues computation. Many of the larger metropolitan societies have substantial reserves or trust funds. Some derive income from other sources—*e.g.*, property rental. In one midwestern city, the county government pays the medical society $9,000 a year for providing rotating professional service in the county hospital. In many such cases, medical society dues are apt to be surprisingly nominal.

What You Get

The size of the society and the extent of its activity bear little relationship to the amount of dues paid. One small county society, for example, requires $40 dues. The society has few organized programs, no paid secretary, and no periodical. Its social as well as its educational activities are small-scale.

Members of another county society have a secretary, an organized campaign against irregular practitioners, a physicians' aid program, and a wide range of other activities. Their dues: only $10.

On the whole, inflation has tended only slightly to push up medical association dues. But in some cases, increased costs have forced individual societies to levy special assessments. —JAMES WILSON

Socialist Tag

[*Cont. from* 87]

And Representative Adams of Pennsylvania described the income tax as "unutterably distasteful both in its moral and material aspects. It does not belong in a free country. The imposition of the tax will corrupt the people. It will bring in its train the spy and the informer. It will necessitate a swarm of officials with inquisitorial powers. It is a direct step toward centralization."

Nor did the postal savings system escape denunciation when it was first introduced during Theodore Roosevelt's administration. The American Bankers Association passed a resolution condemning as "unwise and hurtful all propositions to establish postal savings banks." Said one speaker: "It is entering upon a plan that a free and enlightened nation ought never to touch. Such vast deposits will be the football of politicians and an entering wedge to that deadly peril, paternalism."

Even that essentially conservative piece of legislation establishing the Federal Reserve System did not escape the socialist tag. At the 1913 meeting of the American Bankers Association, the chairman of the association's currency commission said: "There are a great many different theories of socialism; but they all agree upon the fundamental proposition that the Government . . . should own . . . all money-making utilities. For those who do not believe in socialism, it is hard to accept this proposed action."

Like some physicians today, yesterday's bankers feared lay control. "Men trained in the banking business could act with clearer judgment than political appointees selected along partisan lines," said the vice-president of the American Bankers Association. "This is not in any sense a political question. It

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must be solved upon the higher plane of statesmanship and not subjected to the strife and selfishness of political parties."

Health insurance is now added to the list of so-called "socialistic" proposals. It is in good company.

—JAMES E. MURRAY

Placement [*Continued from 80*]

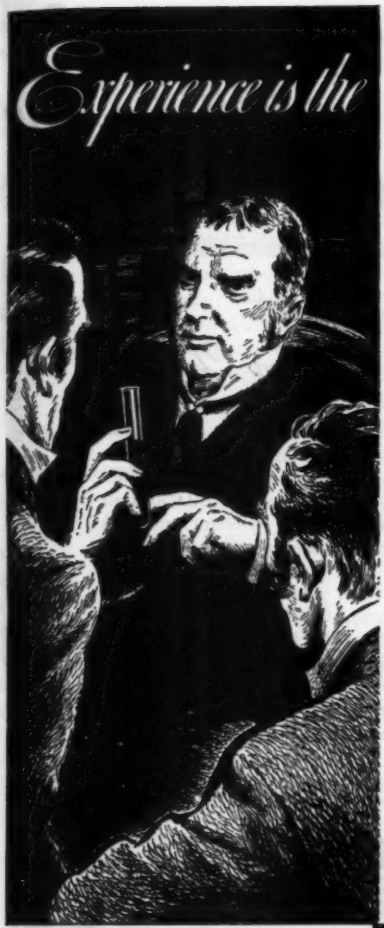
was a decisive factor: The chief of staff had a weakness for the game. A school in Montana wanted a physician to travel with its winter sports team; much depended on the candidate's skill on skis.

Then there's the case of the physician who went out for a job interview and wasn't heard from for three days. When the agency finally reached him by phone, he said he didn't know whether he'd got the position or not. He'd forgotten to ask. The interviewing doctor had turned out to be an old college football teammate. They had spent the weekend practicing drop-kicks.

—MARTIN KEELEY

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.



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Soluble Tablets Crystalline Penicillin G Potassium, 50,000 units each, are supplied in boxes of 24 tablets, each tablet individually wrapped in foil.

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CSC

Open Letter [*Cont. from* 53]

can do for me? The usual, of course. You know it and I know it. Probe and be done with it.

Item 2: When you have accomplished Item 1 and are standing at my side speaking of such things as my calorie, vitamin, and calcium intake, please don't beat an unconscious tattoo on my abdomen and then act delightfully astounded when the being within gives forth with a hefty kick. You, too, would kick if someone were tapping on you. Leave Junior alone—he isn't bothering you.

Privacy Preferred

Item 3: When we have done with Items 1 and 2 and you have signified that our interview is over, don't continue to talk; for you leave me facing a great question: Should I remain in the prone position and take up more time, thus inconveniencing some other bulging beauty in your outer office; or should I spring from the table and struggle into my various uncomfortable garments before your very eyes, all the while trying to put forth with gay little quips and intelligent conversation, as if I were quite used to engaging in such activity while speaking to unrelated men? I prefer, if you don't mind, to hook my garters and regain my poise in the comparative privacy of your pink-and-white room.

Item 4: With all the instructions and tender advice you render your patient at the first interview, you refrain from giving any information at all on the simple little down-to-earth matters I'd really like to know about. Don't you have some suggestions, for instance, on how a specimen bottle should be wrapped so it doesn't look like a specimen bottle wrapped?

Item 5: Perhaps you remember those frequent, tense moments when you stared in astonishment at the record of my unallowed weight gains and asked me *what* I'd been eating this month . . . and when I looked at you so innocently and said only old lettuce leaves and an occasional carrot. Dear Doctor, I was lying. You can't make an endive enthusiast out of an apple-pie addict—not even with that cruel form of torture, the weighing-in.

Item 6: When I am leaving your office, please don't shout out, in full hearing of all the other patients, "Good-bye, now, Mrs. Brown. Watch your diet. Drink a lot of

milk. See you next month!" Don't do that, Doctor! It makes me feel so—well, so pregnant.

Item 7: At last—at long, long last—the great day (or great midnight) arrives and I am stretched on my bed of pain attempting to retain some outward semblance of poise and composure. If a small moan escapes my parched lips, please, oh please, don't say, "Come now, Mrs. Brown, it's not really so bad, is it?" Yes, dear friend, it *is* bad. It is completely horrible. And if I were not so afraid of frightening you away just when I need you most, I would tell you so in definite terms. Just because you are a mere man, and therefore excluded from these ungainly agonies, does not give you the right to belittle my suffering. If I've got to suffer, I want to enjoy suffering and not have you make light of it. And don't send that young, trim, slim nurse in with a tray of food for me. What possible interest do you think I have in soup and pudding when I'm so grimly intent on presenting a new Brown to the world—but quick?

Item 8: Comes the final moment when Brown Junior is arriving. I am rushed down the hall and into that all-white torture chamber. I am frantically trying to be a perfect little patient, to be charming in spite of all—and you come up to me and say, "What do you want? A boy or a girl?" Really now, Doctor! Don't you think it's a bit late for

"Mrs. Beeble, this is Dr. Smith . . . Smith, this is a gallstone."

consulting my wishes on the subject? Here we have gone along these nine months together, each resigned to accepting whatever it is to be, speaking of it in guarded terms as "the infant," "the fetus"—and now you ask me to name my specifications. I want a baby, Doctor, a screaming little object equipped with all its fingers, toes, and other essentials. I don't really care about its gender. I am, in fact, a bit tired of it at this point and wish I were anywhere but in the delivery room—say, out dining somewhere or dancing. Let us bring this child out and away from me, and let us not quibble about such trivialities as its sex.

Item 9: Now it's all over. I am peacefully enjoying my new motherhood and feeling quite pleased with myself in general. You and your colleague approach my bed. You nod at me as if I were just another woman who has had a child, overlooking the fact that I am really The Only Woman who has just given birth to The Only Child. Together you examine me. I pretend boredom. I ought to be used to this by now. Your colleague says, "Beautiful job, old man!" You blush and really look quite proud. "Thank you," you answer with simple modesty, and you leave the room. Your ideas of beauty and mine are curiously dissimilar.

That's all, Doctor. But even if you don't put these reforms into effect, even if you ignore all my careful itemizing, I shall probably return to you anyhow. You were pretty kind to this impatient patient! And when my husband called you that important wee hour, you were there! Which leads me to say that if Brown Junior should some day become a guardian of the growth of tiny embryos into terrible infants, we would be most awfully proud!

Gratefully yours,
Irma Agnes Brown

Letter of the Law

● Our new police chief decided that the department's ambulances were answering too many unnecessary calls, so he ordered that they be used for emergencies only. Shortly afterwards, a man called up and said, "My wife is having a baby. Send an ambulance, and hurry—it's an emergency!"

"Oh yeah?" retorted the desk man. "An emergency is when somethin' happens without warning. You've had nine months to call a cab or a private ambulance. Whatcha tryin' to do, kid me?"

—M.D. CALIFORNIA

Calling Miss Bredow!

Your office trouble-shooter tells how your secretary's letters can be improved

• Q. My secretary turns out letters that are technically correct but messy looking. How can she improve them?

A. The careless correction of typing errors often contributes to an unsatisfactory end-product. Before making an erasure, let your secretary move the typewriter carriage all the way to one side, so that erasure dust doesn't fall into the machine. To make an erasure practically invisible, it's a good idea to smooth it over with chalk. The eraser itself should be kept clean with an emery board. When typing corrections, tap the keys lightly until the characters match those in the rest of the letter.

Two other hints for improving the appearance of letters: (1) Change the typewriter ribbon often; (2) clean the type regularly with alcohol or with a standard solvent.

Q. Should the title "Dr." or the initials "M.D." be used in correspondence?

A. As a rule, use "Dr." in the address and in the salutation. Use "M.D." below the doctor's signature and on printed letterheads. Naturally, both are never used together in the same place.

Q. Should the secretary's initials appear on my letters?

A. It's not necessary except, for example, in a medical group that employs a number of secretaries. (It also helps in such cases to make carbon copies of a different tint for each doctor.)

Q. What secretarial handbook would you recommend to help my aide with her letter-writing and with her other duties?

A. A few of the most popular handbooks are:

"Standard Handbook for Secretaries," by Lois Hutchinson. Whittlesey House, New York, 1947.

"The Secretary's Handbook," by Sarah A. Taintor and Kate M. Monro. Macmillan, New York, 1938.

"The Private Secretary," by John Robert Gregg. The Gregg Publishing Co., New York, 1944.

—MIRIAM BREDOW

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* *The author of this article is Dean of Women, Eastern School for Physicians' Aides. Here she answers questions about business procedure in the medical office.*

Convalescent [*Cont. from* 68]

could be avoided. My home does not admit mental cases, alcoholics, or the senile. Unless you are equipped for such cases, they may prove to be serious liabilities. They disturb the other patients, lower their morale, and eventually may undermine the reputation of your home."

Doctor Gomberg's personal medical care of the patients usually takes only a few hours a day. It consists chiefly of simple medication, routine examinations, and laboratory tests. Because of the limited types of cases admitted, his office requires no special equipment. Patients receive what medical attention they need in their own rooms.

The Chicagoan gives this advice to doctors thinking about opening a convalescent home:

In the Beginning

"Begin on a small scale. When you have established a reputation for good care of patients, the home will begin to expand naturally.

"Remember that you are running a business. Unless you operate profitably, you cannot perform a public service and maintain high standards.

"Investigate carefully before selecting a location. Ask yourself: Will the building meet zoning regulations? Can it pass fire, health, and building requirements? Can it be put into first-class condition, heated and maintained at a cost that will not drag the home into the red? Is there a local need for a convalescent home?

"Use common-sense business efficiency. Costs may be cut by careful purchasing of food and supplies by permitting nurses and other employes to live on the premises, by living on the premises yourself."

As a Starter

Actually, young doctors as well as the middle-aged will find opportunities in convalescent-home management, says Doctor Gomberg. He adds:

"The young doctor, with the aid of his wife, may start with perhaps two or three convalescents in his own home. They will take up very little of his time, allowing him to spend most of each day with other patients.

"Even if he decides not to continue the convalescent home permanently, the added income will help tide him over until he is well established in regular practice."

—CLARENCE E. SUTTON

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for the depressed and nervous patient

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*T.M. Reg. U.S. Pat. Off. for racemic amphetamine sulfate, S.K.F.

Pirating of Medical School Teachers Spurred by Research Grants

Faculty turnover zooms as schools and teachers angle for attractive subsidies

• Stepped-up subsidizing of medical research by private and Government agencies has brought faculty pirating among medical schools to a fine art. Schools are raiding each other for researchers who can attract lucrative research grants. At the same time, a sizable number of younger faculty members shuttle annually from one campus to another in the hope of connecting with research funds. All of which makes teacher turnover a critical problem for many a medical school today.

Most faculty pirating centers around second-string men in the departments. As a rule, professors and department heads stay put. But since assistants are usually appointed on a year-to-year basis, they switch jobs at frequent intervals.

Such raiding has both good and bad aspects. On the credit side is its effect of keeping the younger full-time teachers on their toes. The possibility of capturing an attractive research grant is a strong incentive to make good. On the debit side, of course, is the resulting instability of school faculties. Even more serious is a natural inclination on the part of some teachers to put too much weight on research, not enough on teaching.

Passing Parade

Turnover naturally varies among schools, but some lose as many as a dozen pre-clinical teachers in one year. That makes it hard to maintain the standard ratio of one teacher to twenty-five students in the pre-clinical courses.

Along with this trend has gone an unprecedented switching among medical school deans. In the past four years, sixty-four new deans appeared on school campuses. Although a similar upheaval is not expected soon again, the schools are still feeling the effects.

Raiding of faculties will probably taper off in the future. Until now, a

[*Continued on* 146]

**Dr. Fred C. Zapffe, author of this article, is secretary of the Association of American Medical Colleges.*

Just Published [*Cont. from* 100]

pital for Speech Disorders, New York. Gratis.

THE NATIONAL HEALTH AND S.545. A comparison of the Taft and Wagner health bills. 12 pp. Charts and tables. Research Council for Economic Security, Chicago. Gratis.

IF BIOLOGICAL WARFARE COMES. By Jerome Feiner. All about weapons "as deadly as the A-bomb." Harper's, May.

BOOKS

YOU AND YOUR DOCTOR. By Benjamin Miller, M.D. Group practice, socialized medicine, and other medical-economic developments get a chatty going-over here. 194 pp. Whittlesey House, New York. $2.75.

AMERICAN SEXUAL BEHAVIOR AND THE KINSEY REPORT. By Morris L. Ernst and David Loth. An interpretation for the layman of the most talked-about book of the year. 192 pp. Greystone Press, New York. $1.96.

YOUR PROFESSIONAL OFFICE. By John Gerald Shea. A medical office designer presents material on how to plan and furnish a medical office. Illustrated in two colors, with many sketches and floor plans. 36 pp. Hamilton Manufacturing Co., Two Rivers, Wisc. Gratis.

Reporting Diseases

[*Cont. from* 65]

dents. But several court cases suggest that a physician who renders a report required by law will be upheld even if he misjudged in making his diagnosis.

In California, for example, a woman's test for venereal disease turned out positive. The doctor wrote his patient, explained that he would have to report the case. When she failed to respond, he went to visit her. Neighbors overheard the ensuing discussion, so the woman brought suit for slander. Though she was awarded $3,000 in the lower court, the physician was upheld on appeal—in spite of the fact that the woman was shown later *not* to have had V.D. What helped turn the tables in the physician's favor was his exact compliance with the requirements of the law.

The list of reportable diseases and the requirements to be met in reporting them vary widely from state to state. Only eleven of the common communicable diseases, for example, are reportable in all states. The time allowed for making reports runs the gamut. In some areas, the physician is required to report certain diseases "immediately by telephone or by messenger."

Your best move is to check periodically with your local board of health to make sure that you're up on the latest details.

—ARNOLD G. MALKAN, LL.B.

why this is the ideal phenobarbital preparation for children . . .

ESKAPHEN B ELIXIR

1 Its fluid form makes it easy to take.

2 Its good taste makes it pleasant to take.

3 Its calming action is supplemented by the tone-restoring effect of thiamine.

And this is important, too: Parents who "know all about phenobarbital"—and might be upset at the idea of giving it to their children—won't know you are prescribing phenobarbital when you write ESKAPHEN B ELIXIR.

Smith, Kline & French Laboratories, Philadelphia

Each teaspoonful (5 cc.) contains: phenobarbital ¼ gr. and thiamine 5 mg.

ESKAPHEN B ELIXIR

The delightfully palatable combination of phenobarbital and thiamine

leaves up to his client, but he insists that there be enough to go with the oversize suite.

Typical Boggs touches in the medical office are fresh greenery, fresh magazines, and glass in abundance. Sometimes he may suggest piped-in music to soothe waiting patients. Decorations vary with the client's taste, but the result is sure to stress two of the tutor's obsessions: attractiveness and cleanliness.

Delegation of authority is another hallmark of successful practice, Boggs thinks. "It's silly for doctors to spend time on records or on office routine," he tells Doctor Blank. "Far better to spend that time reading up on medicine or seeing patients. For the patient's sake as well as your own, turn over all the little details to assistants."

That means efficient aides—and that means good salaries. In a typical metropolitan center. Doctor Blank will pay secretary-assistants $75 a week. They pull their weight by freeing him for the practice of medicine.

Boggs passes some interesting cues along to the secretary Blank hires. Typical commandments: (a) "Always know where the doctor is and how to reach him. Never leave the office phone unguarded. Misplaced doctors lose patients." (b) "Be definite about fees. When the patient is through, say, 'That'll be $3, please.' If he doesn't want to pay cash, tell him specifically, 'We'll

to your patients . . .

a most important "ingredient" is TASTE!

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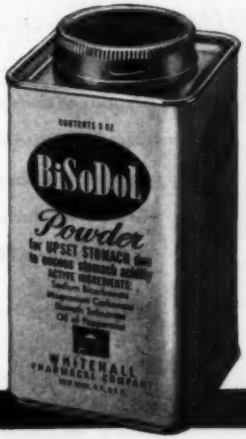

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Adequate nutrition is important during embryonic life when precursors of all organs are developed. Since the fetus depends on the maternal blood for its nutrition, sufficient nutrients must be supplied to meet the increased needs of mother and fetus. OBron presents a convenient means of supplying adequate amounts of calcium, phosphorus, iron and essential vitamins in a single capsule.

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Ferrous Sulfate, U. S. P.	64.8 mg.
Vitamin A (Fish-Liver Oil)	5,000 U. S. P. Units
Vitamin D (Irradiated Ergosterol)	400 U. S. P. Units
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Vitamin C	37.5 mg.
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*(Equivalent to 15 Grains Dicalcium Phosphate Dihydrate)

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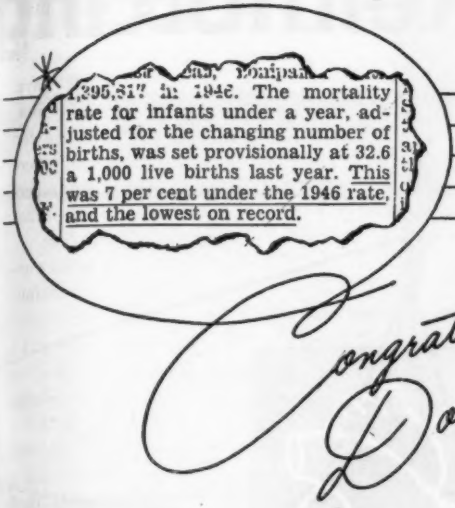
send you a statement.' Then be sure he gets it on the first day of the month."

Boggs doesn't care what particular record system his protege chooses, but he's downright insistent about its being kept up. Often, that means including on record cards even the gist of phone conversations with patients. Even when a system has been in force for years, Boggs still checks it twice a month, goads the doctor and his aides into keeping it up.

While he's checking office equipment, Boggs doesn't overlook the doctor's. He tries discreetly to make Blank clothes-conscious. To get a new client thinking about it, he usually suggests that he buy four or five tailor-made suits. If Blank pooh-poohs the notion that a prosperous air makes for prosperity, Boggs quotes some telling statistics: Controlled experiments, he says, have shown him that a neat-but-not-gaudy wardrobe, plus an eye for such details as shined shoes, properly pressed clothes, and clean fingernails, can increase a doctor's practice by as much as 20 per cent.

Nor does the doctor's extra-curricular life escape E.B.'s scrutiny. He prescribes a full month's vacation for Blank every year. He picks out some after-hours diversion of the doctor's and gets him to enlarge on it. Boggs is not in favor of indiscriminate "joining," but if he can find a club along the lines of Blank's special interests, he suggests that Blank become a member. "It's the



Congratulations to members of the medical profession who have advanced the science of pediatrics and have thereby made the first year of life far less critical.

The official figures showing the reduction in the mortality rate for infants under a year are a tribute to the research, skill, and care that have been so faithfully applied to this important problem.

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* *Herald Tribune Bureau, Washington, D. C., February 24, 1948*

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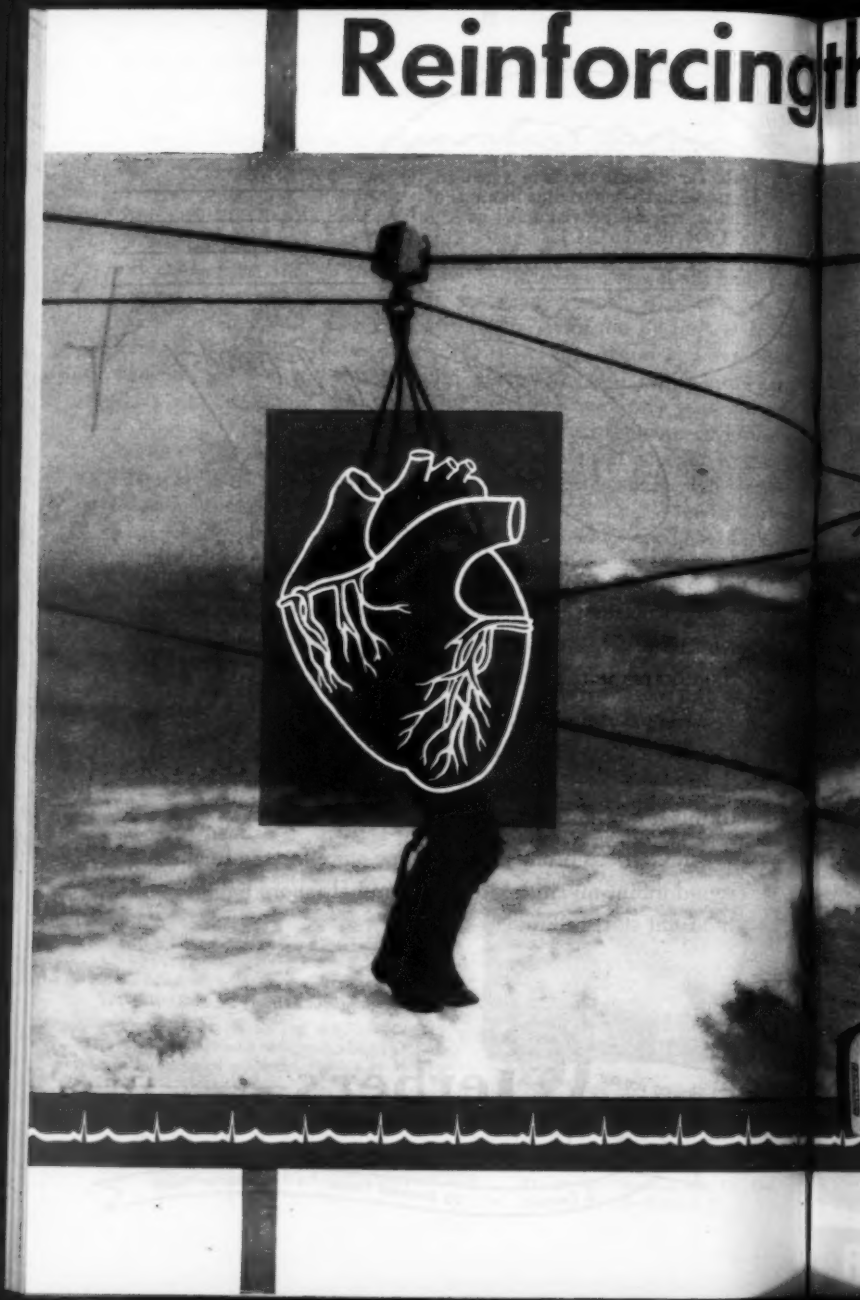
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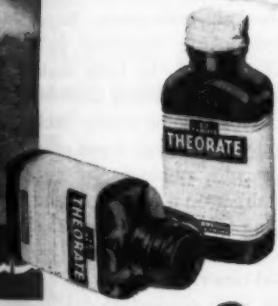
Indications: coronary disease, angina pectoris, congestive heart failure, essential hypertension, Cheyne-Stokes respiration, edema.

Supplied: in bottles of 50 and 500 tablets. Recommended dosage 2 to 4 tablets daily.



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best way of coming to the public's attention favorably," Boggs thinks, "whether your avocation is music, church, chess, or athletics. You don't get so much out of joining a catch-all organization in which you have no real interest."

Boggs knows the value of medical meetings, too, and is not above

checking on Doctor Blank's attendance. Under the heading of discreet professional relations, he also encourages clients to write papers on the fields in which they've developed a special interest. Once they've broken into print, Boggs uses good-looking reprints, judiciously distributed, to help make the authors known among their colleagues. (This scheme nearly backfired once when Boggs went overboard for color photography as a device to dress up a client's reprint. "He's trying to get doctors certified by direct mail," commented one critical old-timer.)

All this may suggest that Ernie

RIASOL
Rings the bell in PSORIASIS

The problem of psoriasis is being solved with RIASOL. That this effective, therapeutic agent "rings the bell", in what has long been a baffling skin condition, is conceded by thousands of doctors who now prescribe it.

Riasol provides a means whereby disfiguring psoriatic lesions clear up promptly in most instances. The number of recurrences is often reduced.

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RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages necessary. After a week, adjust to patient's progress.

RIASOL is ethically promoted. Supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

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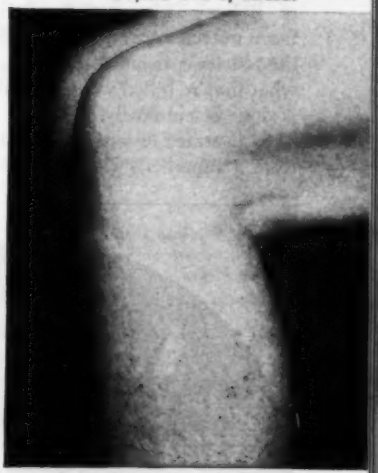

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RIASOL FOR PSORIASIS

Boggs does his thinking with a cash register. On the contrary, though he's a fast man with a figure, he's also exceptionally sensitive to the human element in medical practice. This shows up particularly in the fee-setting tips he gives Doctor Blank.

Says Boggs: "Some people think a medical business manager is there for just one purpose: to get all the public can stand. That's not so. The idea is to scale fees so that they reflect fairly the patient's standard of living. This protects patients from overcharges, yet it improves the doctor's income. Patients pay what they're billed when the billing is done scientifically."

Inaccurate fee-setting often stems from a superficial check of the patient's income status, Boggs thinks. He warns Doctor Blank: "Wives often build up their husbands' jobs. They'll say they're 'managers' of stores when actually they're helping run the place on a fairly low salary." Boggs' own background has given him a wide knowledge of wage differentials. In cases that stump him—about 1 per cent—he gets a credit report on the patient in question.

Setting the Fee

A fee memo for Doctor Blank. "On major medical or surgical procedures, stick to your original estimate of the price, even if you lose money. When you quote a range of prices, such as $150-250 for a given procedure, incline toward

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SQUIBB Procaine Penicillin G for Aqueous Injection

Offering all the advantages of prolonged-action penicillin without the disadvantages of the preparations hitherto available. For use in any condition in which penicillin in oil and wax is indicated.

ONE DAILY INJECTION — An intramuscular injection of 300,000 units of an aqueous suspension of CRYSTICILLIN provides therapeutic blood levels for 24 hours in the majority of patients—and for 36 hours in approximately 50% of patients.

MINIMAL PAIN — CRYSTICILLIN contains no OIL or WAX. Consequently, pain following intramuscular injection is minimal.

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CRYSTICILLIN is supplied in diaphragm-capped vials containing dry procaine penicillin G together with a minute quantity of effective and nontoxic dispersing and stabilizing agents—for suspension with sterile aqueous diluent.

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the smaller when the bill is made out. Both these policies will pay off in good patient relations.

"Sometimes a patient will start wondering out loud whether he 'can afford it' before you've mentioned payment. In such cases, let *him* set the fee. Nine times out of ten, he'll set it higher than you will."

Fees determined according to such rules aren't hard to collect. Practitioners under Boggs' wing collect, on the average, 96 per cent of their bills. "In nearly every case, patients *want* to pay their doctor," Boggs tells Doctor Blank. "If they don't pay, the fault probably lies somewhere in the doctor's office. Among other things, harp on correct names and current addresses. If patients see that the mechanics of the doctor's billing system are unbusiness-like, they may be equally unbusiness-like about paying."

How He Does It

By this time, young Doctor Blank has a pretty fair answer to his original question, "How does Boggs do it?" More than that, he'll soon have a pretty fair practice. The typical Boggs client has to move to larger quarters twice during the first five years. At the end of that time, he's in or near the $30,000-a-year bracket. He's seeing as many as seventy-five patients a day. And Boggs is still checking his business procedures twice a week, his collections once a month—for a proportionately larger fee.

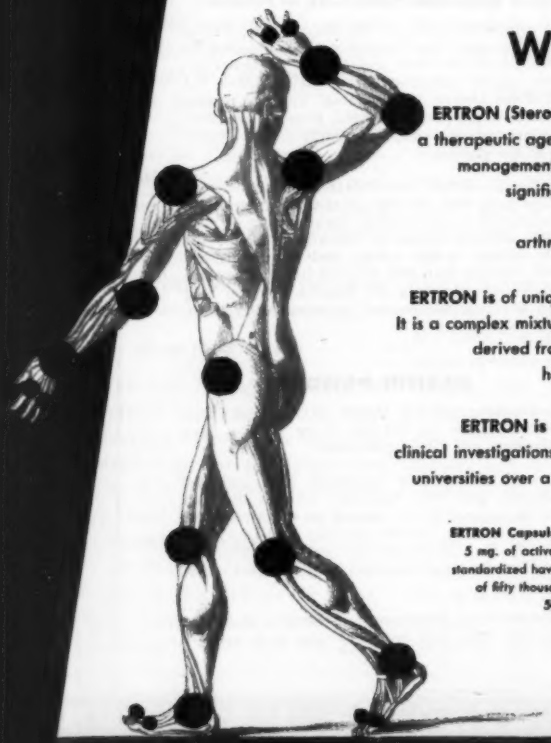
Before they reach that point, a number of Boggs' clients fire him, on the assumption that the wonder has been worked and the wand-waver is no longer needed. Most of these men have discovered that business falls off when Boggs isn't checking it at regular intervals. He has been fired and rehired as many as three times by the same doctor.

Eleven the Limit

At his peak, Ernie Boggs was minding the affairs of sixty-five physicians in thirty-two medical offices (most of them in Detroit, Chicago, and Buffalo). But skipping from office to office was running down his energies, running up his overhead. Today he has narrowed his clientele to eleven specialists, some of whom he visits just once a month. His present list includes some of his top proteges, including one surgeon whose income is in six figures and who pays a substantial chunk of Boggs' annual income.

Outsiders now and then have hinted that there's some black magic about the Boggs formula. He has had two brushes with medical society ethics committees. One came during the depression, when

ERTRON



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ERTRON (Steroid Complex, Whittier) is a therapeutic agent of proved value in the management of chronic arthritis, with significant arthrokinetic effect—improved mobility of arthritic joints—in many cases.

ERTRON is of unique chemical composition. It is a complex mixture of activation-products derived from electrical activation of heat vaporized ergosterol.

ERTRON is relatively safe judged by clinical investigations in leading hospitals and universities over a period of thirteen years.

ERTRON Capsules: Each capsule contains 5 mg. of activation-products biologically standardized having an antirachitic activity of fifty thousand U.S.P. units. Bottles of 50, 100 and 500 capsules.

ON in arthritis

is: What it is not:

ERTRON® is not a panacea or specific designed to supersede medical, surgical or physiotherapeutic measures of acknowledged merit.

ERTRON is not to be confused with vitamin D products obtained by other methods (ultraviolet irradiation) or derived from other sources (fish liver oils).

ERTRON is not likely to produce serious untoward effects when administered under the physician's surveillance with proper observation of contraindications.

ERTRON Parenteral: Each ampule contains activation-products, in sesame oil, biologically standardized having an antirachitic activity of five hundred thousand U.S.P. units. Packages of six 1 cc. ampules.

Nutrition
Research
Laboratories

Chicago 37

he sent a letter to patients saying, in effect: "If you need medical care, don't hesitate to come in for lack of funds. If you can't pay the full rate, pay whatever you can. If you can't pay anything, we'll give you free medical care." Another time, he announced a doctor's change of location with what seemed (to the ethics committee) unnecessary fanfare. In neither case did the medical society finally decide that any wrong had been committed.

Officers of the society today characterize Ernie Boggs as "on the up and up." Among the men who know him best—his clients—even casual comments sound like magazine-ad testimonials. Says one twenty-year veteran, chief of staff in a 600-bed hospital: "Boggs has helped me a lot. He got sound business practices under way in my office. I only get about an hour a month out of him now, but he's worth it. Boggs is a man of high integrity and, in my opinion, is honestly interested in the patients' welfare."

Boggs arrived at his lucrative calling via a spectacularly roundabout route. He was born in Barton, Ohio, a coal-mining town across from Wheeling, W. Va. During his home-town schooling, he picked up his first taste of the business world by clerking in Barton stores. He went to Staunton Military Academy, then to Ohio Wesleyan University (class of 1917), where he acquired the nickname "Shrimp" but no degree.

After that, in bewildering succes-

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More Effective—Lanteen Vaginal Jelly gives greater protection by combining active spermatocidal agents in a jelly readily miscible with the vaginal secretions.

Non-irritating, Non-toxic—Lanteen Vaginal Jelly is bland, safe, soothing and is rapidly destructive to spermatozoa.

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sion, came this kaleidoscope of jobs:

(a) Floor-walking in Wheeling, W. Va. (b) Selling photo-engraving in Canton, Ohio. (c) Stripping coal in Smithfield, Ohio. (d) Selling Studebakers ("awful"). (e) Selling pitch and coal tar. (f) A hitch in the Army Medical Department. (g) Selling paint ("a complete bust—one sale in four months"). (h) Welfare and insurance work with Goodyear Tire & Rubber. (i) Selling vaults and safes. (j) Selling candy to drug stores.

In 1925, Boggs ended this variety act by meeting a man named V. S. Loventhal in Cleveland. Loventhal ran a medical service bureau, and the idea fascinated Boggs. If his background had done nothing else, it had given him a broad smattering of business methods. Physicians obviously stood to gain from this information. In short, Boggs figured he had what doctors needed. He convinced Loventhal and became an associate of his.

The first physician Boggs approached was a dermatologist. The doctor was somewhat allergic to business details, and Boggs' story sounded pretty good. He agreed to pay Boggs $50 a month to keep tabs on his business affairs, but didn't have a very clear idea of how it would be done.

"What are you going to do first?" he asked.

"I don't know," said Boggs. "Every client is different." He didn't mention that this was his first.

This initial triumph, after a good many defeats, probably made it inevitable that Boggs would branch out on his own. When he did, he sent persuasive letters to 300 physicians, telling what he could do for them. Nine signed with him. Personal calls accounted for five additional M.D.'s bedevilled by problems they wanted to unload on someone. Boggs was willing.

A Jump Ahead

More than that, he became increasingly able. Keeping one step ahead of his clients in the art of business management had Boggs panting the first few years. Then his unique, bird's-eye view of several dozen medical practices began to pay off. By comparing one practice with another, he could find out what helped the doctor, what didn't. He began to develop a sizable fund of fee-setting (and fee-getting) kinks, of new ideas in patient relations. And he developed an impressive file of evidence to show that hiring him would build a doctor's practice.

Boggs' love for variety took one unhappy turn in 1929, when he

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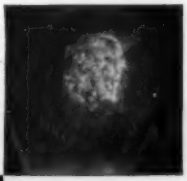

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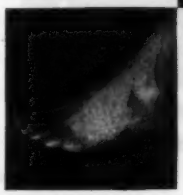
highly effective in an unusually wide range of common skin disorders



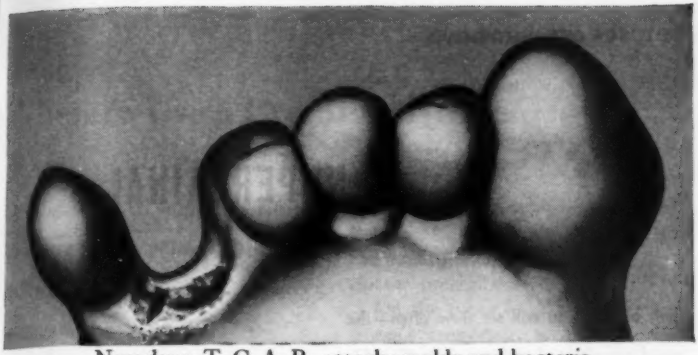
thought the time was ripe to go into the automatic orange juice dispenser business on the side. He dropped $15,000 and backed hastily away. Since then he's stuck to the business of minding other people's business.

Boggs is convinced that medical business management is due for a boom. "The trend toward groups is a shot in the arm for this profession," he says. "A good many solo practitioners need a part-time manager, too." But he shakes his head over the fact that a number of his imitators have turned into "glorified collection agents":

"Collection agencies are pretty sure to create bad will for the doctor," he observes darkly. "They attempt to solve a problem from the wrong angle: by going after the patients rather than by going after the doctor's business methods. Medical service bureaus that emphasize collections have turned away from their real goal: freeing the physician for the practice of medicine."

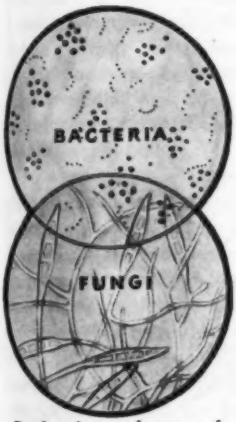
All of which may draw strong dissent from some quarters. But that's nothing new for Ernie Boggs. He's been sniped at a good deal during two decades of minding the doctor's business. To his way of thinking, though, the Boggs formula has meant (a) better service for patients; (b) greater professional success for doctors; and (c) some profitable pioneering for one E. L. Boggs. On all three counts, most people would concede the record bears him out—and then some.

—R. CRAGIN LEWIS



New drug, T. C. A. P., attacks molds and bacteria

Anti-fungal, Anti-bacterial



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Many cases of Athlete's Foot are complicated by pus-forming bacteria, besides the fungi.

Recognized fungicides often fail in Athlete's Foot because they do not attack both bacteria and fungi.

A useful, quickly-effective adjunct in such cases is T-CAP Cream, which is active against both fungi and bacteria. In a water-miscible base, it contains the new drug, T. C. A. P. (trimethyl cetyl ammonium pentachlorphenate) and undecylenic acid.

Striking results are achieved in stubborn, resistant cases, as well as in less complex lesions. Pleasant, soothing base, mild, non-staining. 1-oz. tubes.

New, really effective in Athlete's Foot

T-CAP CREAM

(Formerly T.C.A.P. Fungicidal Ointment)

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Send sample of T-CAP Cream.

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When to Use a Practical Nurse

A leading R.N. suggests how doctors can decide when and where to employ P.N. services

• A few medical spokesmen have suggested the indiscriminate substitution of practical nurses for R.N.'s in the realm of bedside nursing. Such a step would be detrimental and dangerous to the patient's welfare. When there was a critical shortage of doctors, no one suggested that first-aid technicians be substituted for M.D.'s. The same parallel exists here.

Nevertheless, the proper use of well-prepared practical nurses can contribute much. Their sphere is the care of subacute, convalescent, and chronic patients. Since a patient's condition is often transitory, the doctor has to analyze each case frequently—sometimes even on a day-to-day basis—in order to determine whether R.N. services should be resumed or whether they should be discontinued.

Where do you draw the line between R.N. and practical nurse services? In general, the R.N. applies principles of nursing based on biological, physical, and social sciences. She's usually at her best when observing symptoms, recording medical facts, or carrying out the treatments and medications a doctor prescribes.

On the other hand, the practical nurse's true field is the physical care of the patient and the carrying out of doctors' orders that don't need a professional background.

A recent article in MEDICAL ECONOMICS on the practical nurse listed many specific duties that come within her sphere. (For complete details on her capabilities and limitations, consult "Practical Nursing: An Analysis of the Practical Nurse Occupation," published in 1947 by the Federal Security Agency.) But often there are outside factors to consider in assigning jobs to the practical nurse.

The amount of supervision is important, since she can handle certain duties under the guidance of a physician or R.N., but not on her own. There's also a wide variation

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**Ella Best, R.N., author of this article, is executive secretary of the American Nurses' Association. Here she elaborates on this magazine's recent article, "How Practical Nurses Are Helping to Ease the R.N. Shortage."*

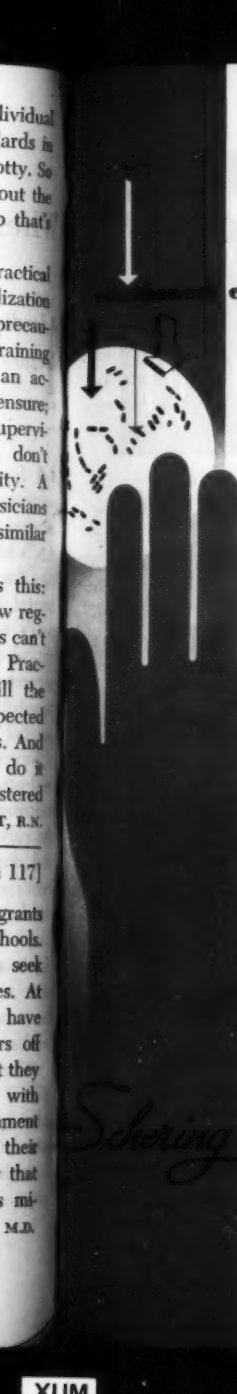
in the competence of individual practical nurses, since standards in this field are still notably spotty. So the physician must think about the individual as well as the job that's involved.

The ANA program for practical nurses suggests increased utilization of their services if three precautions are taken: (1) proper training of at least nine months in an accredited school; (2) state licensure; (3) proper placement and supervision to make certain they don't practice beyond their ability. A good many practicing physicians have given their backing to similar standards.

The gist of the matter is this: Even though there are too few registered nurses, practical nurses can't be substituted for them. Practical nurses may partially fill the gap, but they shouldn't be expected to care for acutely ill patients. And whatever they do, let them do it under a physician's (or a registered nurse's) guidance. —ELLA BEST, R.N.

Teachers [*Continued from* 117]

large proportion of research grants has gone to relatively few schools. This has caused teachers to seek posts on the favored faculties. At the same time, other schools have worked hard to lure teachers off those faculties in the hope that they might bring research funds with them. Now, with Government agencies planning to spread their grants more evenly, it's likely that faculty members will do less migrating. —FRED C. ZAPFFE, M.D.



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cause of urinary tract infections . . .

SULAMYD* searches out and attacks *B. coli* so rapidly that "results that follow its use are uncanny. Occasionally the urine is sterile at the end of one day's treatment."[1]

RECOVERY or improvement in 98% of 200 cases of acute and chronic infections of the urinary tract was noted by Welebir and Barnes,[2] typical of the brilliant results achieved with SULAMYD. For prophylaxis, too,

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BIBLIOGRAPHY: (1) Wesson, M. B.: West. J. Surg. **49**:662, 1941. (2) Welebir, F., and Barnes, R. W.: J.A.M.A. **117**:2132, 1941. (3) Younge, P. A.: Urol. & Cutan. Rev. **49**:422, 1945. (4) Kearns, W. M., in discussion on Herrold, R. D.: Wisconsin M. J. **41**:467, 1942.

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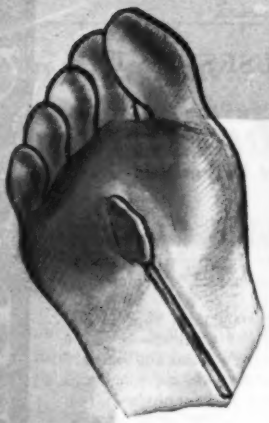

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The Newsvane

Explains Use of M.D. Group Corporation

Medical groups can organize a corporation legally and ethically if they are careful to limit its scope and purpose, says the AMA Bureau of Legal Medicine and Legislation. A corporation may not usually practice medicine; but since certain aspects of practice are exclusively of a business nature, and not concerned with professional practice, they may be ethically and economically carried on by a corporation.

As an example, the bureau cites the type of corporation that holds title to the property of a group and rents it to the physicians. "The income of the corporation," it recently told the Illinois State Medical Society, "could be used to maintain equipment and pay necessary employes, and any surplus used to pay dividends or, preferably, to subsidize research, medical education, and the like. The corporation might furnish the services of such nonprofessional assistants as nurses, technicians, stenographers, etc. It might even attend to the clerical needs of the partnership, such as the reception of patients and the preparation and collection of bills.

"Patients coming to the building would not be patients of the corporation—for it would not undertake to diagnose or treat—but of the partnership. If such a corporation is formed, its existence should be recognized in the partnership agreement."

Distribute Budget Aid For Families

Patients—and doctors—who find it hard to make today's boy-size dollar do a man-size job may get some help from a leaflet called the "Family Money Manager." It's available without charge from the Institute of Life Insurance, 60 East 42nd Street, New York 17, N.Y. The "manager" is not a budget, says the institute, but a simple method for money planning; by using it, a family can get a clear picture of its financial strength and weaknesses.

Sees V.A. Hospitals Not Necessary

The Government should stop building V.A. hospitals because (1) there is not enough professional talent to operate them properly and (2) the Hill-Burton Act will even-

tually provide enough beds for all the population, including veterans. This is the conclusion of Graham L. Davis, president of the American Hospital Association. And he adds: "It is doubtful that there is any justification for the National Government operating hospitals, except, perhaps, for the armed services."

Says Play Pens Help to Foster Frustration

The old cartoon showing the parent safe in the play pen while the destructive infant prowls the home has been given oblique support by a social worker. He is S. R. Slavson of the Jewish Board of Guardians, New York. Mr. Slavson believes the play pen does mental injury to the baby because it "restricts his movements and punishes his spontaneity." Net result, he says, is "an infantile sense of guilt."

Housing Extortionist Gets City Lodging

Languishing in a New York bastille a month ago was a $9,000-a-year lawyer, charged in an eleven-count indictment with having defrauded doctors seeking apartments. He was Meyer Greenwald, 45, formerly employed by the Metropolitan Life Insurance Company to screen applicants for apartments in its housing developments. Authorities say he used his position to exact fees of $2,000-$4,000 from doctors and dentists on the promise of getting them into the new buildings. He collected in this way a total of $28,000.

A.A. Movement Now International

Fifty per cent of inebriates who join Alcoholics Anonymous abandon drinking immediately; 25 per cent backslide once or twice; and 25 per cent are "improved," says A.A. Membership now totals 60,000 and is spread through the U.S., England, South and Central America, and Australia.

Wants Wide-Open Field for Psychiatrists

An all-out program of extra-curricular activity for psychiatrists has been proposed by Dr. Carl A. Binger. He wants them to put in their oars at every level of public activity, from the local school board to the United Nations. Doctor Binger says psychiatrists should act

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as trouble-shooters when things go wrong at U.N. meetings, help diplomats understand each other, even "storm the fastnesses of the State Department." And he adds: "Perhaps diplomats could get some training in psychiatry, or psychiatrists some experience in diplomacy."

Doctors Teach Health in High Schools

"Interested? These youngsters can't seem to get enough." So say seventy-one private practitioners who are conducting a voluntary program of health lectures in the seven public high schools of Dallas, Tex. (pop. 300,000). The physicians—representing general medicine, gynecology, urology, surgery, and pediatrics—conduct health classes of from thirty to forty-five minutes each, totaling about two days a month.

The project was started in 1946 by several of the younger members of the Dallas County Medical Society. They believed that doctors, not laymen or nurses, should give health instruction to youngsters. Education authorities backed them and a program was evolved for 1946-47. It was so successful that a more comprehensive seminar was soon instituted.

Each physician now prepares his own lecture, basing it on an outline and source material supplied by

Man-made Rain

Water fixed in clouds may be precipitated by solid CO_2 scattered from an airplane. Man has learned to unlock clouds.

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1. Rehabilitation Through Better Nutrition, 1947 — Spies
2. Journal of American Medical Association, Oct. 27, 1945; 129:653 - Jolliffe
3. Vitamin Deficiencies: Stigmas Symptoms and Therapy (J.A.M.A., June 22, 1946; 131:666- Council on Foods and Nutrition).

the medical society's educational committee. The session winds up with a question-and-answer period. Pupils' interest runs high.

Would Bar Insurance to Careless Physicians

Physicians "guilty of acts for which no excuse, in common decency, can be found" should be excluded from cooperative plans of malpractice insurance, the New York State medical society has been warned. The society's malpractice insurance board, after studying an existing group contract, declares that such insurance "appears, in too many instances, to have dulled the edge of judgment, to have assumed too much of the physician's responsibility to his patient, to have shielded the unworthy, and to have fostered the very carelessness it was intended to offset."

It is useless to plead with offenders to mend their ways, says the board; the only remedy lies in studying each case of alleged malpractice and canceling the insurance of any member whose actions or medical procedures cannot be justified.

Foresees Atomic-Age 'Walking Dead'

Every doctor must become familiar with the Geiger counter, which he'll have to use as a diagnostic instrument in the event of atomic warfare. So says Dr. John H. Lawrence of the department of medical physics, University of California. His recommendation is emphasized by Dr. Stafford L. Warren, who studied A-bomb victims in Hiroshima and Nagasaki. Says Doctor Warren: "Many persons might walk around for twenty-four to seventy-

two hours after an atomic explosion, apparently in the best of health, before dying. They have got to be sorted out. We must learn to differentiate between those on the borderline and the walking dead."

Asks End of Health Grant Hodgepodge

A stern warning has come from the Federal Bureau of the Budget that legislators must stop piling grants-in-aid programs one atop another. "The ultimate aim," declares the bureau, "should be one health grant to states for specific health purposes. The present system needlessly complicates planning, administration, and reporting by state and local governmental units. It tends to hamper the development of a well-integrated health program in the state and nation."

The bureau, whose power is keenly felt by Congressmen, has singled out the National Heart Institute bill, sponsored by Senator Claude D. Pepper (D., Fla.), as super-imposing "still another state-grant program upon five existing grant programs for health." Actual

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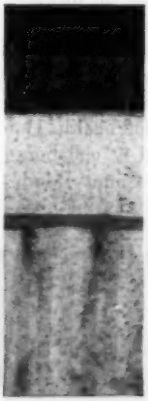
Microphotograph of cross section of Feosol Tablet

A special protective coating of fatty esters prevents oxidation of the ferrous sulfate to the relatively ineffective ferric form.



1 Outer coating

2 Under coating

3 Protective fatty esters

4 Compressed ferrous sulfate

ly, says the bureau, the heart program can be efficiently carried out under the existing Public Health Act.

Neuroses That Bloom In the Spring

Springtime is a vastly overrated season of the year, reports Dr. William F. Petersen, Chicago authority on the pathogenic effects of weather. A young man's fancy is as likely to turn to thoughts of suicide as of love, come April or May, says Doctor Petersen. He points out that more people die, go insane, or kill themselves during the three spring months than in any other quarter. "Temperatures rise and fall sharply and suddenly," he continues. "People, drained of energy and vitamins during the winter, are wide open for anything that comes along."

Newspaper Spotlights Medical Society

Public comprehension of medical problems got a sturdy boost in Dallas, Tex., recently when the Daily Times Herald got out an eighteen-page Sunday supplement devoted entirely to medicine and health. The section was prepared in collaboration with the Dallas County Medical Society and with the faculty of Southwestern Medical College, many of whose members wrote special articles for the supplement.

Included in the feature section were informative articles on a dozen diseases, on the city's hospitals and health insurance plans, and on its medical school. The purpose: to let a good portion of the city's 300,000 residents know "what's what with Dallas medicine."

Cost of Cancer X-Ray Program Seen High

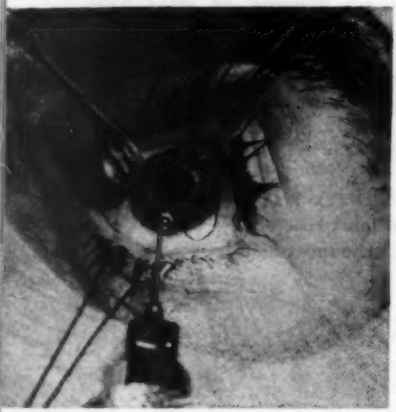
Don't place too much dependence on cancer detection clinics, warns the American College of Radiology; such centers can reach only a "tiny fraction of the population." Actually, says the college, "the success or failure of any cancer-control program is going to depend in a large measure on the skill, knowledge, and attitude of the attending physician or family doctor."

Dr. R. R. Newell of San Francisco sums up the problem. "It is true," he says, "that a human life is priceless, and that discovery of a case of cancer in a curable stage is worth any amount of money and effort. But this philosophy can be applied to only one person. If you apply it to everybody, you run into

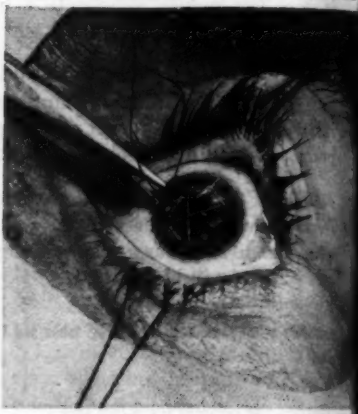
The graft removed from the donor eye. ▲

Patient's cornea outlined with the trephine. ▲

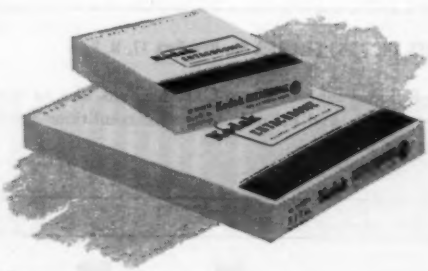
▼ Donor graft shown ready for insertion.



▼ Operation completed with the sutures tied.



Reproduced from color photographs of corneal grafting operation, performed under the auspices of the Eye-Bank for Sight Restoration.



Serving mo ress t

Bridging sutures placed around cornea. ▲

Button removed with trephine and scissors. ▲

icture the atient's progress

ith photograph...after photograph

e to be a photographer? No. Many physi- —amateurs in photography—are making e-and-after "shots" routine procedure in ignificant cases . . . building up valuable for study, discussion, teaching.

OUTINE, TOO, has become the use of color. Especially since the recent introduction Kodak Ektachrome Film with its excep- al color rendering and speed of handling. ith this film, the physician or photog- er is able to record medical or surgical ations—get quick local processing . . . or, e processes the film himself, see trans- ncies in a little more than an hour.

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the difficulty that time and money are available in only finite amounts, and must be allocated to all the other essential things of life.

"In 6,000 pelvic examinations on apparently well women, only three early cases of cervical cancer were found. Eight hundred symptomless persons over 45 had to be X-rayed in order to find one gastric cancer . . . These examinations have to be done by expensive talent. The discovery cost might be $7,000 or $8,000 [per case]."

Mass X-raying for tuberculosis is far more practicable, says Doctor Newell, since the cost per case is only about one one-hundredth that for cancer. Furthermore, he points out, "every case discovered and controlled lessens the tuberculosis hazards for everybody else."

New Prepay Agency Being Mapped Out

A good many physicians were stirred early this year by talk of a Blue Cross - Blue Shield merger. They reasoned that a unified organization would streamline administration and silence comments about "expensive duplication." They thought that a national enrollment corporation made possible by the merger would beef up enrollment.

But the merger idea has now been discarded. In its place, a separate agency is being blueprinted that would transact all joint business of the Blue Cross and Blue Shield commissions. Business not of a joint nature would be handled by the two agencies as before, since each would retain its individual identity. Those who opposed the merger as a threat to their jobs see no such bogey in the present plan. Pretty general acceptance of it is therefore predicted.

Operating instructions for the new association are scheduled to be ready by next winter. Its organizational pattern will probably look something like this:

Control would rest with a fifty-six man board, weighted equally with medical and hospital representatives. The board would have power to act for Blue Cross and Blue Shield in joint business and to set up a nonprofit insurance corporation. The expectation is that it could thus supply uniform benefits to em-

Case History of an overweight streetcar-operator . . .

'Dexedrine' Sulfate — because it curbed appetite and lowered food intake—enabled even this extremely obese patient to lose weight easily and safely without the use (and risk) of such potentially dangerous drugs as thyroid.

Patient before treatment (age 53; height 5' 10½") weighed 352 pounds . . . was suffering from hypertension, nervousness and dyspnea . . . lived in fear of causing an accident while on duty. Overeating was the only demonstrable cause of his obesity.

Therapy: 'Dexedrine' (15 mg. A.C. t. i. d.)	Results: Weight	B. P.	Pulse
March, 1946 . . . . . 'Dexedrine' therapy begun	352	280/152	86
November, 1946 . . 8th month of 'Dexedrine' therapy .	269	160/84	86
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In addition to the weight reduction of 118 pounds and the concurrent lowering of blood pressure, a remarkable improvement is reported in the patient's mood and outlook. Earlier nervousness and fears have vanished.

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ployes in industries operating in more than one state; it could also offer coverage to people in areas without local plans. To calm fears that the national corporation would siphon off business from local plans, local administration of national accounts would be the general rule.

Even the plan described does not enjoy unanimous support. However, most prepay officers are behind it, and the few reluctant ones are expected to join in despite their reluctance. If everything proceeds on schedule, the new agency will begin to roll early in '49.

Every Physician A Columnist

Members of the Lake County (Ind.) Medical Society are finding out what a columnist's life is like. A group selected from their ranks prepares a daily health column called "Your Doctor Says," appearing in the Gary Post Tribune. Panel membership is changed every month, so that the whole medical society will eventually have taken part in the scheme.

Rosenwald Fund Hands Out Last Dollar

Having spent $22 million, including $3½ million for health work, the Rosenwald Fund closed its books last month and went out of business. During thirty-one years of dollar-dispensing, the fund had ticketed $2 million to develop health services for Negroes and $1½

million to establish clinics and to promote hospital insurance for persons of modest means.

The money handed out by the Rosenwald Fund stemmed from the capital and income of 227,784 shares of stock in Sears, Roebuck & Co., the mail-order company that had made a fortune for Julius Rosenwald. Mr. Rosenwald, who believed that each generation should take care of its own problems, had stipulated that the work of the foundation be concluded within twenty-five years of his death. The actual closing date came only seventeen years after he died.

Though the Rosenwald Fund has shut down, its influence will continue to be felt in health circles. Still active is one of its offshoots, the Rosenwald Family Association, angel of the left-leaning Committee on Research in Medical Economics and similar groups.

Society Sizes Up D.C. Hospitals

The kind of care patients get in Washington's public institutions is being scrutinized by a new committee of the District of Columbia medical society. In periodic visits that will become a regular feature of the society's activity, the committee will appraise not only medical care but the physical plant as well. The survey team will be ready to go to bat for increased Federal appropriations for institutions that need more money.

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Medical Economics

JANUARY-JUNE 1948

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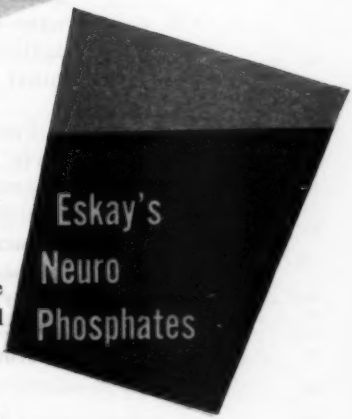
The benefit of a good tonic is not entirely limited to its tone-restoring and appetite-stimulating effects.

Most physicians know how much the little ceremony of taking each pre-meal dose of Eskay's Neuro Phosphates can brighten "the endless, daily, dull routine" of the elderly patient's life.

And—of great importance—"her tonic" is an ever-present symbol of the reassuring and comforting fact that she is "in the care of her physician."



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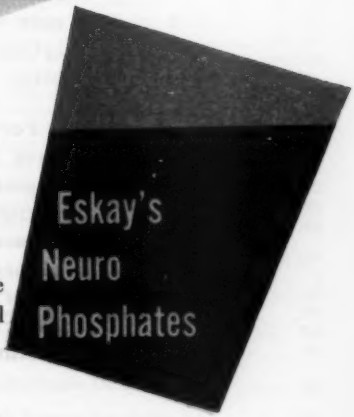

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Riboflavin	10 mg.	2 mg.
Pyridoxine hydrochloride	1 mg.	*
Calcium pantothenate	10 mg.	*
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Jolliffe and Smith stress that "*The daily therapeutic dose of vitamins should be at least five times the maintenance requirements. Since they can be given in amounts many times the maintenance requirements without untoward effect, it is better to give too much than too little.*"[3]

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1. Haven Emerson: Journal Lancet, 57:1, 1947.
2. Registered trademark, Sharp & Dohme.
3. M. Clin. North America 27:567, March 1943.

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